COVENTRY

Health Care of Delaware, Inc.

STATE OF DELAWARE SUMMARY PLAN DESCRIPTION

Visit Our Website at
www.chcde.com

TABLE OF CONTENTS

COVENTRY HEALTH CARE OF DELAWARE, INC.
STATE OF DELAWARE EMPLOYEE BENEFIT PROGRAM
SUMMARY PLAN DESCRIPTION

ARTICLE 1 - INTRODUCTION

The State of Delaware ("the Employer") has established a self-funded Employee Benefit Program (hereinafter called the "Health Plan," "We," "Us," or "Our") to provide its employees and their dependents with a comprehensive and dependable system of obtaining health care services.

The Employer has entered into an agreement with Coventry Health Care of Delaware, Inc. ("CHC") whereby CHC will provide certain managed care services to the Benefit Plan.

Since CHC is acting as an administrator of the Benefit Plan, it is understood that any reference to CHC in this Agreement is not to be interpreted as imposing financial responsibility on CHC regarding compensation to Participating Providers and other Providers. The financial responsibility remains with Your Employer.

The Health Plan between Coventry Health Care of Delaware, Inc. and You and Your Dependents as Members of the Health Plan is made up of:

- this Summary Plan Description and amendments;
- the Group Enrollment Form; and
- any Supplemental Benefit Explanations or Riders.

This Summary Plan Description will assist You in taking full advantage of Your membership. It explains how to receive care, what to do in an emergency, and other important information about Your rights and responsibilities as a Member.

Please read the Summary Plan Description carefully!

Make sure that Your enrolled family members are familiar with the Benefit Plan and know how to use it. If You have any questions, please call:

Customer Service Department
Local Calls: (302) 283-6500
Toll Free: (800) 833-7423

ARTICLE 2 - COVERAGE PRINCIPLES

2.1 MEMBERSHIP IDENTIFICATION CARD

Every Coventry Health Care Member receives a membership identification card. Carry Your identification card with You at all times, and present it whenever You receive care from a Physician, Hospital, or other Provider. You may not permit anyone else to use Your card to obtain care. If You permit someone else to use Your identification card, or You misuse or deface Your identification card, Your membership will be terminated under Article 11.2.B of this Health Plan. We will notify You in the event such termination is necessary.

2.2 MEDICAL NECESSITY (MEDICALLY NECESSARY)

Only services that are Medically Necessary are covered under this Health Plan. All determinations relating to Coverage, including Medical Necessity, are determined by the Health Plan.

2.3 THE PRIMARY CARE PHYSICIAN

At the time You complete Your Group Enrollment Form, You must select a Primary Care Physician for yourself and each family Member. You may choose a Primary Care Physician for the entire family or a different Primary Care Physician may be selected for individual family Members.

If You wish to change Your Primary Care Physician, contact Customer Service and request reassignment to a different Primary Care Physician. The change is effective on the date of Your request. You may change Your Primary Care Physician no more than twice a year, unless extenuating circumstances exist.

You and Your Primary Care Physician will work together to maintain Your good health. Your Primary Care Physician will provide and coordinate Your health care needs. This may include routine health problems, consultation with specialists and other Providers, Medical Emergency care, Urgent Care and hospitalization.

If You require medical attention, contact Your Primary Care Physician's office. Primary Care Physicians are responsible for providing 24-hour coverage for their patients, including after normal business hours as well as on weekends and holidays. If Your Primary Care Physician is unavailable, You may be referred to a Physician on-call.

Your Primary Care Physician or Participating Provider may bill You if You fail to keep a scheduled appointment. If You are unable to keep a scheduled appointment, call Your Primary Care Physician's or Participating Provider's office as soon as possible to cancel the appointment.

2.4 REFERRALS AND AUTHORIZATIONS

Members must:

- Receive medical care from the Member’s Primary Care Physician of record; or
- Receive a referral from the Member’s Primary Care Physician before obtaining health services except for Medically Necessary gynecological care received from a participating obstetrician/gynecologist.

A. Authorizations

An “Authorization” is an approval of a benefit by Us in advance of the Member receiving certain services. We use a series of reviews to make sure the use of health care services is appropriate for Your condition. Participating Providers are responsible for obtaining Authorization from Us before a Member receives the service. For more information about Notice of Benefit Determinations, see Article 2.9.

Some services also require authorization by Coventry Health Care. Participating Providers are responsible for obtaining authorization for Your care. The following is a list of services requiring authorization by Coventry Health Care:

- Ambulance Transport (except for emergency situations)
- Chemotherapy
- Colonoscopy or Endoscopy
- Computed Tomography Scans (CT Scans)
- Devices and implant biological materials associated with spinal fusion and intervertebral disc replacement
- Durable Medical Equipment purchase price greater than $200 – all rentals require authorization (personal, comfort and convenience items are a benefit exclusion)
- Eye Glasses or Corrective Lenses Required after Cataract Surgery
- Genetic Counseling
- Hair Prosthesis
- Home Health Care
- Home Infusion Therapy
- Hospice
- Infertility Services
- Injectables
- Inpatient Admission (i.e., Hospitals, Rehabilitation, Surgery, Skilled Nursing Facilities and Sub-Acute Facilities)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Maternity Care (for prenatal care prior to hospitalization and inpatient care following 48 hours of a vaginal delivery or 96 hours of a cesarean section)
- Non-Participating Provider (except for Emergency Services)
- Nutritional Counseling performed by Providers other than Participating Physicians
- Outpatient procedures and surgical services performed in a hospital
- Plastic/Cosmetic Surgery and procedures
- Positron Emission Tomography (PET Scans)
- Therapies (i.e., Speech Therapy, Physical Therapy, Occupational Therapy, Cardiac Rehabilitation/Therapy and Pulmonary Rehabilitation)
- Transplant and Transplant Evaluation

Please check the back of Your ID card for the number to call for Prior Authorization of Mental Illness, Emotional Disorders and Alcohol and Drug Abuse services.

If you are unable to receive the authorized service on the assigned date of service or time span You were given during the Prior Authorization process, You must notify Your physician who will contract Us to update the Prior Authorization. CHCDE will provide notification of the approved new date of service or time span to You and Your Physician.

B. Referrals

A “Referral” is a Primary Care Physician’s assignment of a Member to a specialist without the need for the Health Plan’s authorization. Referrals do not need written notice to or permission from Us in order for the Member to receive specialist care.

In some cases, the Member may receive a standing referral to a specialist if all of the following conditions are met:

- The Primary Care Physician of the Member determines, in consultation with the specialist, that the Member needs continuing care from the specialist.
- The Member has a condition or disease that is life threatening, degenerative, chronic or disabling, and the referral specialist is a Participating Provider. The standing referral shall be made in accordance with a written treatment plan for a covered service developed by

the Primary Care Physician, the specialist and the Member. A treatment plan may limit the number of visits to the specialist; limit the period of time in which visits to the specialist are authorized; and require the specialist to communicate regularly with the Primary Care Physician regarding the treatment and health status of the Member. Benefits are provided for referrals, procedures, tests, and other medical services provided or requested by the Specialist during the treatment period when such services are otherwise covered under this Health Plan and, if necessary, approved by Us.

- The Member may request a standing referral for pregnancy to an obstetrician. The obstetrician will be responsible for the primary management of the Member's pregnancy, including referrals through the postpartum period. A written treatment plan may not be required when a standing referral is to an obstetrician.

The Member shall receive a referral, standing referral or standing referral for pregnancy from the Member's Primary Care Physician before obtaining health services; except for Medically Necessary gynecological care received from a participating obstetrician/gynecologist and nurse midwives.

A Member may request a referral to a non-participating specialist if:

- The Member is diagnosed with a condition or disease that requires specialist medical care;
- We do not have a Participating Specialist with the professional training and expertise to treat the condition or disease; and
- The Specialist agrees to accept the same reimbursement as would be provided to a Specialist who is a Participating Provider.

2.5 PARTICIPATING PHYSICIANS AND PROVIDERS

We reserve the right to make changes in Our Participating Physician and Participating Provider network as is appropriate or necessary. A Member may get information about our Primary Care Physicians and other Participating Providers by

- checking the Provider Directory;
- calling our Customer Service Department at (800) 833-7423; or
- logging on to our website at http://www.chcde.com/.

2.6 PAYMENT TO PROVIDERS

Payment of benefits for Covered Services will be arranged by Us to be made directly to the Participating Physician or Participating Provider of the service. For Medical Emergency and Urgent Care services, payment will be made by Us directly to the Provider or may, at Our discretion, be made to the Member. Participating Physicians and Participating Providers may not, under any circumstances, seek payment from Our Member except for approved Copayments and Coinsurance, or for unauthorized or non-Covered Services.

2.7 COPAYMENTS AND COINSURANCE

Members are responsible for paying Copayments to Participating Providers at the time of service. Copayment and Coinsurance amounts, listed on the Schedule of Benefits incorporated into this Health Plan, must be paid regardless of the level of service a Member receives.

2.8 MEMBER RESPONSIBILITY FOR PAYMENTS

A Member must pay for all services not provided or referred in advance by the Primary Care Physician and not authorized by Us. An exception to this provision is in a Medical Emergency or Urgent Care situation. Refer to Articles 5.19 and 5.20 for further details.

2.9 NOTICE OF BENEFIT DETERMINATION

A. Definitions

Authorized Representative: An individual authorized by the Member or state law to act on the Member's behalf to submit appeals and file claims. A Provider may act on behalf of a Member with the Member's express consent, or without the Member's express consent in an emergency situation.

Medical Emergency: the sudden and acute onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Notice of Benefit Determination: A notice of approval, denial, reduction or termination of benefits, or the failure to provide or pay for benefits.

Pre-service Claim: A request for a benefit for which authorization is required in advance of the Member obtaining medical care for a service that has not already been provided.

Post-service Claim: A claim for medical care that the Member has already received or any claim that is not a Pre-service Claim.

Urgent Care Claim: A claim for medical care or treatment for which

- the application of the time periods for making non-urgent care determinations
  - could seriously jeopardize the life or health of the Member, or the Member's ability to regain maximum function; or
  - in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or
- We determine that a prudent lay person who possesses an average knowledge of health and medicine would judge to be an emergency; or
- that a physician with knowledge of the Member's medical condition determines is a claim involving a Medical Emergency.

An "Urgent Care Claim" may be a claim for a Medical Emergency.

B. Urgent Care Claims

Claims for Medical Emergency care rendered in an emergency room or Urgent Care Center are not subject to this section.

When We receive a request for urgent treatment that is not rendered in an emergency room or Urgent Care Center and satisfies the requirements of the Urgent Care Claims definition, We will notify the Member and/or the Authorized Representative of the decision, whether adverse or not, by telephone within one business day and in writing no later than 72 hours after the request is received. If there is insufficient information for Us to make a decision, We will notify the Member and/or Authorized Representative no later than 24 hours after receiving the request for emergency treatment, detailing the information that is needed. The Member and/or Authorized Representative has 48 hours to provide the requested information. We will make the decision no later than 48 hours after the earlier of

- the receipt of the additional information; or
- the end of 48 hour period in which the Member or Authorized Representative has to provide the information.

If the request is not approved, the Member or Authorized Representative may appeal the decision as described in Article 10.

C. Pre-Service Claims

When We receive a request for prior authorization of a hospital admission or other service, We will notify the Member and/or Authorized Representative of the authorization decision no later than 15 days after the request is received. We may extend this time period for an additional 15 days if We do not have all the necessary information to make the authorization decision. We will notify the Member and/or Authorized Representative of the need for an extension and explain in detail what information is required. We must receive the information within 45 days from the receipt of the notice to provide the additional information.

If the authorization procedures are not followed, We will notify the Member and/or the Authorized Representative of the failure to follow the procedures within 5 days of the request for authorization. The notice will include the proper procedures to be followed to request authorization.

If the request is not approved, the Member or Authorized Representative may appeal the decision as described in Article 10.

D. Post-Service Claims

We will send a notice of benefit determination (an Explanation of Benefits) to the Member or Authorized Representative within 30 days after we receive the claim. We may extend this time period for an additional 15 days if We do not have the necessary information to make the determination. We will notify the Member or the Authorized Representative of the need for an extension and explain in detail what information is required. The Member or Authorized Representative has 45 days from the receipt of the notice to provide the additional information.

If the request is not approved, the Member or Authorized Representative may appeal the decision as described in Article 10.

E. Ongoing Treatment

We do not reduce or terminate care that is already authorized, as long as the information We were provided to obtain Our authorization is accurate and the Member remains enrolled in the Plan. If We are requested to extend care beyond what we have authorized, We will make a decision on the extension within 24 hours after we receive the request, if such request is made within 24 hours prior to when the authorized care will end.

2.10 MEMBER RIGHTS AND RESPONSIBILITIES

CHCDE is dedicated to ensuring quality medical care and service while preserving Your rights and encouraging You to exercise Your responsibilities. To do this, CHCDE reviews, approves and publicizes the following Member Rights & Responsibilities.

As a Member of CHCDE, You have the right to:

- Receive information about CHCDE, including Your rights and responsibilities, products, directory of participating providers and the plan's policies and procedures.
- Receive information on the amount, duration, and scope of all benefits and services included and excluded as a condition of Your enrollment in the plan.
- Offer suggestions for changes in policies and procedures.
- Prompt notification of termination or changes in benefits, services or provider network. To the extent practical, You will be informed of such termination or changes before the effective date.
- Obtain information that is readable and easily understood.

- Choose a primary care provider within the limits of the covered benefits and plan network including the right to refuse care from specific providers.
- Be treated with respect, courtesy, and recognition of Your dignity with consideration of Your privacy, personal values and beliefs.
- Confidentiality, privacy and security of Your medical records and other information as well as the right to access Your medical records in accordance with Federal and State laws. CHCDE will act to ensure that the confidentiality of Your specified information and records is protected.
- Not be discriminated against because of age, sex, race, creed, color, marital status, national origin, physical or mental handicap, health status, or need for health care services.
- Participate with providers in decision making about Your health care and treatment decisions. The information will be provided in a language You understand.
- Receive from Your doctor, an explanation of Your complete medical condition, recommended treatment, risk of treatment, expected results, and reasonable medical alternatives.
- Call Us whenever You have a question about Our HMO or Your benefits. We are here to serve You.

As a Member of Coventry Health Care, You have the **responsibility** to:

- Review all membership and benefit materials carefully and to follow the guidelines pertaining to Your specific plan.
- Treat others with respect and consideration.
- Provide information needed by professional staff to care for You.
- Follow instructions and guidelines given by those providing health care services.
- Keep scheduled appointments and to contact the appropriate person when You're late or in need of canceling an appointment.
- Always present Your Coventry Health Care identification card when obtaining health care services.
- Inform Us of any additional health insurance You or Your family may have so that payments can be properly coordinated between Us and the other insurer.

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

If You elect breast reconstruction in connection with a mastectomy, You are entitled to coverage under this Agreement for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Such services will be performed in a manner determined in consultation with the attending physician and the patient.

ARTICLE 3 - SCHEDULE OF BENEFITS

The State of Delaware Group Health Insurance Program has no pre-existing condition clause.

Always contact your Primary Care Physician (PCP) any time you need care, though many services no longer require prior authorization.

BENEFITS	**MEMBER PAYS**
Preventive Medical Services	
Periodic Physical Exams by PCP	$10 copayment per visit
Routine Gynecological Exam & Pap Smear	
• PCP's Office	$10 copayment per visit
• Specialist's Office	$10 copayment per visit
Routine Well-Child Care	
• PCP's Office	$10 copayment per visit
• Specialist's Office	$20 copayment per visit
Immunizations by PCP	$10 copayment per visit
Mammogram	$15 copayment per visit
Routine Vision Exam (one exam every 24 months)	$15 copayment per visit
Hearing Tests by PCP	$5 copayment per visit
Diabetes Education	$0 copayment
In the Hospital	
Room and Board (Semiprivate)	$100 per day; $200 maximum per admission
Physician and Surgeon Services	$0 copayment
Maternity Services	
Prenatal and Postnatal Care *	
• 1st Visit	$20 copayment
• Subsequent Visits	$0 copayment
Physician's Delivery Fee	$0 copayment
Birthing Center	$0 copayment
*Additional testing in the physician's office outside the global fee may require additional copayments.	
Hospice	
In lieu of acute care hospitalization	$0 copayment
Home Care Services	
In lieu of acute care hospitalization	$0 copayment
Emergency Room Services	
(Copay waived if admitted)	$135 copayment
Urgent Care Services	
At PCP's Office	$10 copayment per visit
At Specialist's Office	$20 copayment per visit
At Medical Aid/Urgent Care	$35 copayment per visit

BENEFITS	MEMBER PAYS
Serious Mental Illness & Substance Related Disorders	
Inpatient	$100 copay per day; $200 copay per admission
Partial Hospitalization and Residential Treatment	$100 copay per day; $200 copay per admission
Outpatient	$20 copayment per visit

Please refer to the Supplemental Benefit Explanation for Mental Health Care Services for benefits for non-Serious Mental Illness. All services must be provided by a Participating Provider and require Authorization by Us.

Other Services	
Inpatient Private Duty Nursing	Not covered
Outpatient Private Duty Nursing (In lieu of acute care hospitalization)	$0 copayment
Prosthetics & Durable Medical Equipment	20% coinsurance; limited to $5,000 per Member per calendar year
Skilled Nursing Facility	$0 copayment
Emergency Ambulance	$50 copayment
Services Outside the Hospital	
PCP Visits	$10 copayment per visit
Home Visits	$25 copayment per visit
Specialist Care	$20 copayment per visit
Chiropractic Care	$20 copayment per visit
Allergy Testing	$20 copayment per visit
Allergy Treatment (injections)	$5 copayment per visit
Lab	$5 copayment per visit
X-ray	$15 copayment per visit
MRA, MRI, CT, DEXA and PET Scans	$25 copayment per visit
Short-Term Physical Therapy (for up to 45 visits per condition)	20% coinsurance
Short-Term Speech & Occupational Therapies (for up to 60 consecutive days from date of onset)	20% coinsurance
Outpatient Surgery	
(Oral surgery is only covered for removal of bony impacted wisdom teeth)	
• PCP's Office	$10 copayment per visit
• Specialist's Office	$20 copayment per visit
• Surgi-Center	$30 copayment
• Outpatient Hospital	$75 copayment
Family Planning	
Sterilization, Male or Female	Outpatient surgery copay applies
Family Planning and Infertility Services	
• PCP's Office	$10 copayment per visit
• Specialist's Office	$20 copayment per visit
In-Vitro Fertilization (Limit of $30,000 lifetime maximum cumulative for all plans)	Copayment based on type of service

ARTICLE 4 - WELLNESS AND PREVENTION GUIDELINES

These guidelines are provided to heighten Your awareness of the preventive wellness benefits available through Your Health Plan. This schedule was developed from national association guidelines such as those established by The American Cancer Society and the American Academy of Family Physicians. This schedule is subject to change.

To receive the maximum benefits available to You, make an appointment with your Primary Care Physician.

Age	Recommended Preventive Service	Recommended Frequency
15 and Under	Please consult Your Primary Care Physician for recommended services and recommended frequency.	
16-29	**Exams:**	
	• Physical Exam with Health Counseling	Yearly.
	• Blood Pressure Check	Yearly.
	• Pelvic Exam and Pap Smear	Yearly.
	• Breast Exam	Yearly by physician and monthly self-exam.
	• Routine Eye Exam	Every 2 years.
	• Testicular Exam	Monthly self-exam.
	Testing and Screening:	
	• Chlamydia Screening	Routine screening for women age 25 and under and who are sexually active, and in other women with risk factors for infection.
	• Rubella Serology or Vaccination History	Screen for rubella susceptibility by history of vaccination or by serology for all women of childbearing age at their first clinical encounter.
	Immunizations:	
	• Diphtheria/Tetanus	Every 10 years.
	• Hepatitis B Vaccine	Up to age 18 if previously recommended doses were missed or given earlier than the minimum age, and to those over age 18 who are high risk, such as Members on dialysis.
	• Measles, Mumps & Rubella (MMR)	Up to age 18 if previously recommended doses were missed or given earlier than the minimum age.
	• Measles and Mumps	For all Members born after 1956 who lack evidence of immunity to measles.
	• Varicella Vaccine	Up to age 18 if previously recommended doses were missed or given earlier than the minimum age, and to those who live in environments with a high likelihood of varicella transmission (residential institutions, colleges).
	• Hepatitis A	For high risk Members.
	• Meningococcal Vaccine	Feshman college students (ages18-24 years)

Age	Recommended Preventive Service	Recommended Frequency
30-39	**Exams:**	
	• Physical Exam with Health Counseling	Yearly.
	• Blood Pressure Check	Yearly.
	• Pelvic Exam and Pap Smear	Yearly.
	• Breast Exam	Yearly by physician and monthly self-exam.
	• Routine Eye Exam	Every 2 years.
	• Testicular Exam	Performed by physician at ages 30 and 35, and monthly self-exam.
	Testing and Screening: (May be done in any participating laboratory)	
	• Cholesterol	Periodic screening for men beginning at age 35 (screening for women begins at age 45).
	• Mammogram	Baseline for women who are at least age 35.
	• Chlamydia Screening	Routine screening for women with risk factors for infection.
	• Rubella Serology or Vaccination History	Screen for rubella susceptibility by history of vaccination or by serology for all women of childbearing age at their first clinical encounter.
	Immunizations:	
	• Diphtheria/Tetanus	Every 10 years.
	• Hepatitis B Vaccine	For high risk Members, such as Members on dialysis.
	• Measles and Mumps	For all Members born after 1956 who lack evidence of immunity to measles.
	• Varicella Vaccine	For Members who live in environments with a high likelihood of varicella transmission (residential institutions, colleges).
	• Hepatitis A	For high risk Members.
40-59	**Exams:**	
	• Physical Exam with Health Counseling	Yearly.
	• Blood Pressure Check	Yearly.
	• Pelvic Exam and Pap Smear	Yearly.
	• Breast Exam	Yearly by physician and monthly self-exam.
	• Routine Eye Exam	Every 2 years.
	• Glaucoma check (if referred by Primary Care Physician)	Every 3 years.
	• Testicular Exam	Yearly by physician and monthly self-exam.

Age	Recommended Preventive Service	Recommended Frequency
40-59 Cont'd	**Testing/Screening:** (May be done in any participating laboratory)	
	• Chemistry Profile (blood work)	Every 5 years.
	• Cholesterol	Periodic screening for men beginning at age 35 and for women beginning at age 45.
	• Hemoglobin	Females – every 3 years. Males – every 5 years.
	• Urinalysis	Yearly.
	• Routine Mammogram	Every 1-2 years for women age 40-49, but no sooner than 2 years after the baseline; every year for women age 50 and over.
	• Prostate Specific Antigen (PSA) Test	Yearly for men age 50 and over.
	• Chlamydia Screening	Routine screening for women with risk factors for infection.
	• Colorectal Cancer Screening – any combination of the following:	For Members 50 years of age or older.
	• Fecal Occult Blood Test (3 specimens)	Yearly.
	• Flexible Sigmoidoscopy	Every 5 years.
	• Colonoscopy	Every 10 years.
	• Double Contrast Barium Enema	Every 5 years.
	Immunizations:	
	• Diphtheria/Tetanus	Every 10 years.
	• Hepatitis B Vaccine	For high risk Members, such as Members on dialysis.
	• Measles and Mumps	For all Members born after 1956 who lack evidence of immunity to measles.
	• Varicella Vaccine	For Members who live in environments with a high likelihood of varicella transmission (residential institutions, colleges).
	• Hepatitis A Vaccine	For high risk Members.
	• Influenza Vaccine	For Members age 50 and older who are residents of chronic care facilities or who are at risk due to certain conditions (i.e., cardiopulmonary disorders, renal dysfunction).
	• Rubella Serology or Vaccination History	Screen for rubella susceptibility by history of vaccination or by serology for all women of childbearing age at their first clinical encounter.
	• Pneumococcal	Once per lifetime for individuals under age 65 who are at high risk for pneumococcal disease (institutionalized persons age 50 and over, chronic renal failure, etc.).
60 and Over	**Exams:**	
	• Physical Exam with Health Counseling	Yearly.
	• Blood Pressure Check	Yearly.

Age	Recommended Preventive Service	Recommended Frequency
	• Pelvic Exam and Pap Smear	Yearly.
	• Breast Exam	Yearly by physician and monthly self-exam.
	• Routine Eye Exam	Every 2 years.
	• Glaucoma check (if referred by Primary Care Physician)	Every 3 years.
	• Testicular Exam	Yearly and monthly self-exam.
	Testing/Screening: (May be done in any participating laboratory)	
	• Chemistry Profile (blood work)	Every 3 years.
	• Cholesterol	Periodic screening for men and women.
	• Hemoglobin	Females – every 3 years. Males – every 5 years.
	• Urinalysis	Every 3 years.
	• Mammogram	Yearly.
	• Prostate Specific Antigen	Yearly.
	• Chlamydia Screening	Routine screening for women with risk factors for infection.
	• Colorectal Cancer Screening – any combination of the following:	For Members 50 years of age or older.
	• Fecal Occult Blood Test (3 specimens)	Yearly
	• Flexible Sigmoidoscopy	Every 5 years
	• Colonoscopy	Every 10 years
	• Double Contrast Barium Enema	Every 5 years
	Immunizations:	
	• Diphtheria/Tetanus	Every 10 years.
	• Hepatitis B Vaccine	For high risk Members, such as Members on dialysis.
	• Varicella Vaccine	For Members who live in environments with a high likelihood of varicella transmission (residential institutions, colleges).
	• Hepatitis A Vaccine	For high risk Members.
	• Influenza Vaccine	For Members age 50 and older who are residents of chronic care facilities or who are at risk due to certain conditions (i.e., cardiopulmonary disorders, renal dysfunction).
	• Pneumococcal	Once per lifetime at age 65.

ARTICLE 5 - COVERED SERVICES

If so specified on the Schedule of Benefits, the following health care services are covered under this Health Plan, subject to any benefit limitations, Copayments or Coinsurance. Members must receive an authorization from their Primary Care Physician and Us for most services (see Article 2.4 for more information). Any medical service, prescription drug, medicine, equipment, supply or procedure directly or indirectly related to a condition that is not Medically Necessary or not a Covered Service is excluded.

5.1 PROFESSIONAL SERVICES

A. Care While Hospitalized.

During hospitalization, services of Physicians and ancillary medical personnel, surgical procedures, and consultation with and treatment by specialists are covered.

B. Primary Care Physician Services

Office visits to the Primary Care Physician are Covered such as:

- Well child care;
- Immunizations as recommended by the American Academy of Pediatrics or other nationally recognized agency (except those immunizations which are experimental or required for travel or employment);
- One routine annual gynecological examination and Pap smear, but not sooner than 12 months after the previous year's examination;
- Periodic physical examinations (except exams required for employment, school, camp, sports, licensing, adoption or marriage, or those ordered by a third party);
- Allergy testing and treatment, including serum and the administration of injections;
- Periodic hearing screening and audiometric testing;
- Routine eye screening to determine the need for refraction; and
- Health education such as instructions on achieving and maintaining physical and mental health and preventing illness and injury.

C. Specialist Services

Office visits to a Specialist are covered when provided or Referred by the Primary Care Physician and Authorized by Us.

D. Other Services for Diagnosis and Treatment.

Coverage is provided for:

- Services provided by other duly licensed medical professionals;
- CA-125 monitoring of ovarian cancer subsequent to treatment; and
- Dialysis services.

5.2 PREVENTIVE HEALTH SERVICES

Preventive health services are provided according to the wellness and prevention guidelines specified in Article 4.

5.3 HOSPITAL CARE

Inpatient Hospital services, including but not limited to, room and board; general nursing care services; use of equipment and supplies; use of operating room; recovery room; treatment room; and semi-private room or private room when Medically Necessary; intensive care and related Hospital services; anesthesia; internal prosthetics; and medication are covered.

Outpatient facility services, including but not limited to, x-ray and laboratory and ambulatory surgery are covered.

5.4 X-RAY, LABORATORY AND DIAGNOSTIC TESTS

X-ray and laboratory tests, services and materials, including, but not limited to, diagnostic and therapeutic X-rays and isotopes, electrocardiograms and electroencephalograms are covered.

5.5 BLOOD

Administration, storage and processing of blood and blood products are covered.

5.6 MEDICATIONS AND ALLERGY SERVICES

A. Medications.

Injectable medications used for therapeutic purposes are covered.

B. Allergy Testing, Allergy Serum and Administration of Injections.

Allergy testing, allergy serum and the administration of injections are covered.

5.7 MATERNITY CARE

Maternity care rendered by a Physician or midwife is covered before and during confinement, and during the post-partum period. Hospital facility services including delivery room or birthing room are covered. Professional services (including operations and special procedures such as Cesarean Section), anesthesia, injectables, X-rays, and laboratory services are also covered.

Note: Additional Testing in the Physician's office outside the global fee may require additional copayments.

5.8 NEWBORN CARE

A newborn Dependent Child is covered from the moment of birth for 31 days. The subscriber must request enrollment within 31 days of the child's birth in order to continue coverage. A birth certificate or legal documentation needs to be supplied to your State of Delaware Agency Benefit Representative. If the subscriber does not request enrollment within 31 days of the child's birth, the child will have to wait for the next Open Enrollment Period to continue coverage.

Covered Services for newborn Dependent Children shall consist of coverage of Injury or Illness including the Medically Necessary care and treatment of diagnosed congenital defects and birth abnormalities. This includes, but is not limited to, inpatient or outpatient medical and dental (orthodontic and oral surgery) treatment for birth defects known as cleft lip and cleft palate.

5.9 AMBULANCE SERVICE

Ground or air ambulance service for a Medical Emergency is covered.

5.10 SHORT-TERM OUTPATIENT THERAPY

Benefits are provided for short-term therapy as follows:

- Physical, speech, and occupational therapy are covered when needed to restore normal physical function or impairment due to trauma, stroke, surgical procedure or other acute condition and when significant improvement will be achieved through relative short-term therapy. The following limits apply:
  - Physical therapy – covered for up to 45 visits per condition.
  - Speech and occupational therapy – each therapy is covered for up to 60 consecutive days from the date therapy begins for each occurrence. (for example, surgical intervention initiates a new occurrence).
- Pulmonary and cardiac rehabilitation therapies are limited to treatment for conditions that are subject to significant improvement of a Member's condition through relatively short-term

therapy. Each therapy is covered for up to 60 consecutive days from the date therapy begins for each occurrence.

If the Participating Physician and the Medical Director or Medical Director's Designee determines within the first 2 weeks of therapy that the Member's condition will not significantly improve within the period specified above, benefits for therapy and/or treatment will be discontinued.

5.11 TRANSPLANT SERVICES

A. Services related to Medically Necessary organ transplants are covered when approved by Us and performed at a Coventry Transplant Network participating facility approved by Us.

Donor screening tests are covered and are subject to a lifetime benefit maximum of $10,000 when performed at a Coventry Transplant Network participating facility approved by Us.

If not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-covered individual when the recipient is a covered individual will be covered for the duration of the contract of the covered individual when approved by Us.

The cost of any care, including complications, arising from an organ donation by a covered individual when the recipient is not a covered individual is Excluded.

B. Travel for Transplant Services

Travel expenses for members and living donors are covered according to Our transplant travel benefit. Details of the transplant travel benefit will be provided upon request and at any time Transplant Services are authorized. Members are covered when CHCDE is the primary insurer and a Coventry Transplant Network participating facility approved by Us is used.

C. Transplant Services rendered by a Provider not in the Coventry Transplant Network.

Transplant Services rendered by a Provider not in the Coventry Transplant Network are not Covered. Specifically, even if the Transplant Services are rendered by a Participating Provider, unless such Participating Provider is also a participating Coventry Transplant Network facility, there is no Coverage for such services.

5.12 HEALTH SERVICES IN A MEDICAL CLINICAL TRIAL

Coverage is provided for the Routine Patient Care Cost to a Member in a Medical Clinical Trial for randomized and controlled Phase III treatment of a life threatening disease, if such expenses are Covered under this Agreement, authorized in advance by Us, and if:

- the purpose of the trial is the evaluation of an item or service that is covered under this Agreement and not excluded;
- the trial is not designed exclusively to test toxicity or pathophysiology.
- the trial has therapeutic intent;
- the trial of therapeutic intervention enrolls patients with a diagnosed disease;
- the principal purpose of the trial is to test whether the intervention potentially improves the Member’s health outcomes;
- the trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use;
- the trial does not unjustifiably duplicate existing studies; and
- the trial is in compliance with Federal regulations relating to the protection of human subjects.

“Routine Patient Care Cost” means all items and services that are otherwise generally available to a Member covered under this Agreement that are provided in the clinical trial, except:

- the investigational items or service itself;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member; and
- items and services customarily provided by the research sponsors free of charge for any participant in the trial.

Clinical trials must be approved or funded by use of the following entities:

- one of the National Institutes of Health (NIH);
- an NIH Cooperative Group or center that is a formal network of facilities that collaborate or research projects and have an established NIH-approved peer review program operating within the group (for example, the NCI Clinical Cooperating Group and NCI Community Clinical Oncology program);
- the federal Departments of Veterans' Affairs or Defense;
- an institutional review board of a Delaware institution that has a multiple project assurance contract approved by the Office of Protection for the Research Risks of the NIH; and
- a qualified research entity that meets the criteria for NIH Center Support grant eligibility.

Coverage is not provided for Phase I and Phase II clinical trials and any randomized and controlled Phase II clinical trials for treatment of cancer that are not sanctioned by the National Cancer Institute (NCI), or for the cost of any investigational drug.

5.13 SURGICAL SERVICES

Benefits are provided for surgical services rendered in a hospital, the physician's office or ambulatory surgical center.

A. Oral Surgical Services

Oral surgical services are covered, limited to the functional restoration of structures other than teeth (i.e., treatment of trauma resulting in fracture of jaw or laceration of mouth, tongue or gums). Surgery to remove bony impacted wisdom teeth is covered.

B. Reconstructive Surgery

Repair of disfigurement resulting from an Injury, reconstruction incidental to surgery, and surgery that substantially improves functioning of any malformed body part are covered.

C. Mastectomy and Breast Reconstruction

Medically Necessary mastectomies are covered. If a Covered Individual elects breast reconstruction following a Medically Necessary mastectomy, the following benefits are also covered:

- reconstruction of the affected breast;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications at all stages of the mastectomy, including lymphedema.

5.14 CORRECTIVE MEDICAL APPLIANCES

Crutches, casts, splints and other corrective medical appliances, such as orthopedic braces, are covered when medically necessary.

5.15 SKILLED NURSING FACILITY

Care in a Skilled Nursing Facility, only when in place of acute care hospitalization, is covered. Skilled Nursing Facility coverage includes medical supplies and equipment and drugs and biologicals ordinarily furnished by the Skilled Nursing Facility.

5.16 HOME HEALTH CARE

Home health care for diagnostic and therapeutic services is covered when:

- the service is ordered by a Physician and approved by the Primary Care Physician if appropriate under the benefits package;

- the services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist;
- the services are a substitute or alternative to hospitalization;
- part-time intermittent services are required;
- a treatment plan has been established and periodically reviewed by the ordering Physician;
- the agency rendering services is Medicare certified and licensed by the state of location; and
- authorized by the Health Plan.

Participating Physician's home visits within the Service Area are covered.

5.17 PRIVATE DUTY NURSING

Special or private duty nursing is covered when rendered in the home, determined to be Medically Necessary through Case Management and with the goal of transitioning care to caregiver. Inpatient private duty nursing services are not covered.

5.18 HOSPICE

Hospice services, rendered by a state licensed hospice are covered. The Member must, in the judgement of the Participating Physician, have a life expectancy of six (6) months or less.

5.19 CHIROPRACTIC SERVICES

Chiropractic services, including, but not limited to, an initial consultation, diagnosis and treatment of diseases relating to subluxations of the articulations of the spine and its adjacent tissues are covered.

5.20 MEDICAL EMERGENCY SERVICES

A Medical Emergency is the sudden and acute onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Examples of a Medical Emergency are heart attack, cerebrovascular accident, poisoning, convulsions and severe bleeding. We may find that other similar acute conditions are or are not Medical Emergencies. Examples of routine care that do not qualify as Medical Emergencies are sprains, influenza, colds, ear infections, and nausea. Services provided by an emergency facility for non-Medical Emergencies are not covered.

Coverage for a Medical Emergency includes screening examinations or other evaluations required to determine whether a Medical Emergency exists, and treatment and stabilization of the Medical Emergency. Treatment following stabilization of the Medical Emergency is covered when the Medical Emergency treatment originated in a Non-Participating emergency facility and We approve such treatment. We will review and either approve or disapprove coverage of poststabilization care within one hour from the time of the request.

Services for Medical Emergencies are covered when the rules explained below are followed. Members who do not follow the rules may be liable for all costs associated with Medical Emergency services.

A. In the Service Area.

When a Medical Emergency occurs in the Service Area, a Member should seek medical attention immediately from a Hospital, Physician's office or other emergency facility. The Member must notify Us within forty-eight (48) hours of the onset of the Medical Emergency, or within a reasonable period as dictated by the circumstances. The determination of covered benefits for services rendered in an emergency facility is based on Our review of the Member's emergency room medical records, along with those relevant symptoms and circumstances that preceded the provision of care. Services provided by an emergency facility for non-Medical Emergencies are not covered.

B. Outside the Service Area.

When a Medical Emergency occurs outside the Service Area, a Member should seek medical attention immediately from a Hospital, Physician's office or other emergency facility. The Member must notify Us within forty-eight (48) hours of the onset of the Medical Emergency, or within a reasonable period as dictated by the circumstances. The determination of covered benefits for services rendered in an emergency facility is based on Our review of the Member's emergency room medical records, along with those relevant symptoms and circumstances that preceded the provision of care. Services provided by an emergency facility for non-Medical Emergencies are not covered.

The Member may be transported from outside the Service Area to the Service Area for continued medical management of an emergency condition at the option of the Health Plan. We will only exercise this option when Our Medical Director or Medical Director's Designee decides that such action will not have a detrimental effect on the Member's medical condition. Ground ambulance transportation to return a Member to a Participating Provider is covered when authorized by Us. Refusal to be transferred may result in loss of benefits.

5.21 URGENT CARE SERVICES

A condition that requires Urgent Care is an unexpected Illness or Injury that is not life-threatening but requires prompt medical attention. Examples of Urgent Care conditions include fractures, lacerations or severe abdominal pain.

Services for Urgent Care conditions are covered when the rules explained below are followed. Members may be liable for all costs associated with Urgent Care services when these rules are not followed.

A. In the Service Area.

If a condition requiring Urgent Care develops while a Member is in the Service Area, the Member must call his or her Primary Care Physician's office for medical evaluation and instructions. Treatment may be available at the Member's Primary Care Physician's office.

B. Outside the Service Area.

If a condition requiring Urgent Care develops outside the Service Area, a Member may go to the nearest Urgent Care Center, Physician's office or any other Provider for treatment. However, We must be notified of the treatment within forty-eight (48) hours, condition permitting. This treatment may be subject to a Copayment by the Member. The treatment must be a Covered Service and be retroactively approved by Us.

5.22 SERVICES FOR SERIOUS MENTAL ILLNESS

Treatment of Serious Mental Illness is covered when provided, referred or authorized by a Provider or affiliate designated by Us. We determine the Provider, type and duration of treatment, and selection of licensed or certified facility or program.

A “Serious Mental Illness” is any of the following biologically based mental illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo affective disorder and delusional disorder.

The diagnostic criteria set out in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders will be used to determine whether a member is suffering from a Serious Mental Illness. Coverage is provided only for a Mental Disorder that is listed above and determined by US to be a Serious Mental Illness.

For information concerning benefits for non-serious mental illness, see the *Supplemental Benefit Explanation for Mental Health Care Services.*

5.23 TREATMENT FOR SUBSTANCE-RELATED DISORDERS

Benefits are provided for inpatient and outpatient treatment of Substance-Related Disorders. Treatment includes but is not limited to Detoxification and Rehabilitation services. Covered services must be provided, referred or authorized by a Provider or affiliate designated by us and are subject to the limitations and exclusions described herein. We determine the provider, type and duration of treatment, and selection of facility or program. Benefits for Substance-Related Disorders are provided at the same level as inpatient and outpatient services for physical illness.

5.24 FAMILY PLANNING SERVICES

Family planning counseling, information on birth control, insertion and removal of intra-uterine devices, and measurement for contraceptive diaphragms are covered when listed in the Schedule of Benefits.

5.25 ELECTIVE STERILIZATIONS

Male or female surgical sterilizations are covered, when listed in the Schedule of Benefits.

5.26 INFERTILITY SERVICES & IN VITRO FERTILIZATION

Diagnosis and surgical treatment of involuntary infertility and associated X-rays, laboratory procedures, and medication administration as well as in vitro fertilization are covered for You and Your spouse only. There is no coverage for infertility services or in vitro fertilization if you or your spouse have had a voluntary sterilization procedure.

Benefits are provided up to a lifetime maximum dollar limit of $30,000 of allowable charges for Artificial Insemination, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) procedures performed by an approved facility on an outpatient basis. Benefits must be authorized by Your Primary Care Physician and Us.

Benefits are provided only for women who are at least age 18 and have not reached age 45. A pre-treatment plan must be submitted to Us for approval before the services are rendered. The benefit will be provided only if there is a proven infertility problem. All other methods of treatment for infertility must have been exhausted except for tubal reconstruction. The infertility and/or IVF benefits will not cover the costs for or associated with donor services nor the cryopreservation and/or thawing of embryo and/or sperm.

Approved outpatient Artificial Insemination, IVF, GIFT, and ZIFT procedure claims will be paid (up to the $30,000 maximum) in the same manner as the professional service charges for other outpatient surgery. The Artificial Insemination, IVF, GIFT and ZIFT procedures and services covered in the $30,000 maximum are:

- Office visits;
- Surgical services;
- Hospital outpatient charges;
- Anesthesia;
- Laboratory charges; and
- Prescription drugs

Any Artificial Insemination, IVF, GIFT or ZIFT services provided to Your spouse will count towards Your $30,000 lifetime maximum. Claims paid for Artificial Insemination, IVF, GIFT and ZIFT

procedures will be combined in the calculation of the $30,000 maximum. The $30,000 lifetime maximum applies to all health care plans provided by the State of Delaware Group Health Insurance Programs. Any Artificial Insemination, IVF, GIFT and ZIFT benefits paid will be carried as a credit towards the maximum regardless of whether You remain in or switch from Coventry Health Care's benefit program to another during your lifetime.

If Your coverage under this benefit plan terminates for any reason, no benefit will be paid for services rendered after the date of termination, regardless of any pretreatment approval.

If pregnancy results, charges associated with the pregnancy are covered according to the terms of Article 5.7, Maternity Care.

5.27 PROSTHETIC DEVICES

Certain prosthetic devices are covered when listed in the Schedule of Benefits or Supplemental Benefit Explanation. These include external devices (such as artificial limbs, eyes and breast following a mastectomy) and internal devices (such as hip prosthesis, lens implant and breast implant following a mastectomy). External devices are limited to one each per Member per lifetime, except if a bilateral mastectomy is performed. The replacement and repair of prosthetic devices are covered when deemed Medically Necessary by Us.

5.28 DURABLE MEDICAL EQUIPMENT

Durable medical equipment is covered if it:

- is listed in the Schedule of Benefits or Supplemental Benefit Explanation;
- is primarily and customarily used to serve a medical purpose;
- can withstand repeated use;
- is appropriate for use in a Member's home; and
- is on Our Durable Medical Equipment Reference List.

The replacement and repair of durable medical equipment are covered when deemed Medically Necessary by Us.

5.29 DIABETIC EQUIPMENT AND SUPPLIES

When prescribed by a physician, benefits are provided for the following equipment and supplies for the treatment of diabetes:

- Insulin pumps,
- Blood glucose meters and strips,
- Urine testing strips,
- Insulin,
- Syringes,
- Pharmacological agents for controlling blood sugar, and
- Any other equipment or supplies as approved by Us.

Diabetic equipment and supplies will be paid at either the same level as durable medical equipment or as a prescription drug, whichever is applicable. Diabetic supplies which would have been dispensed at a pharmacy and normally covered under an outpatient drug benefit are not covered if a Prescription Drug Rider is not a part of this Health Plan.

5.30 VISION CARE

Subject to the exclusions and limitations described below, benefits are provided for an eye examination to include the following services when rendered at the Participating Provider's discretion and if Medically Necessary:

- Medical history;
- Evaluation of visual acuity;

- External examination of the eye;
- Binocular measure;
- Ophthalmoscopic examination;
- Medication for dilating pupils and desensitizing the eyes for tonometry;
- Summary and findings to determine the need for vision correction;
- Prescribing lenses, if needed.

At least 24 months must have elapsed since You last received vision care benefits.

Excluded are:

- Drugs or other medications not administered for the purpose of the vision examination;
- Special or unusual procedures, such as, but not limited to, orthoptics, vision training, subnormal vision aids, rehabilitative services, topography, or services which are experimental in nature;
- Services provided by a non-Participating Provider, except in an emergency as determined solely by the Health Plan;
- Cosmetic eye surgery which includes any surgery for the improvement of appearance rather than the correction of vision.

5.31 HEARING LOSS SCREENING

Benefits are provided for hearing loss screening tests of newborns and infants provided by a hospital before discharge, provided, however, that if the newborn is expected to remain in the hospital for a prolonged period, testing shall be performed prior to the date on which he or she attains the age of three months.

ARTICLE 6 - EXCLUSIONS AND LIMITATIONS

The following services are excluded under this Health Plan unless otherwise noted as a limitation.

6.1 GENERAL EXCLUSION

Any services, Hospital, professional or otherwise, which are not performed, arranged, authorized, and approved in advance by the Member's Primary Care Physician and Us are excluded, except for those services specified in Article 2.4. This exclusion shall not apply to Medical Emergencies in or outside the Service Area and Urgent Care services outside the Service Area. We reserve the right to evaluate and determine coverage for care not directly provided by a Participating Physician or Participating Provider.

6.2 SERVICES NOT MEDICALLY NECESSARY AND NOT COVERED

We exclude any medical service, prescription drug, medicine, equipment, supply, or procedure directly or indirectly related to a condition that is not Medically Necessary, or that is not a Covered Service.

6.3 EMERGENCY FACILITY SERVICES

Services provided in an emergency facility that are not for a Medical Emergency are excluded. Medical Emergency services are described in Article 5.19.

6.4 PERSONAL OR CONVENIENCE ITEMS

Personal or convenience items such as special diets; in-Hospital television, telephone, private room unless Medically Necessary; and housekeeping, homemaker service, and room and board as part of home health services are excluded.

6.5 AMBULANCE SERVICE

Non-Medical Emergency ambulance services are excluded.

6.6 EYEGLASSES AND CORRECTIVE LENSES

Eyeglasses and corrective lenses are excluded except as necessary for the first pair of corrective lenses following cataract surgery performed while a Member of the Health Plan and obtained from a Participating Provider by a referral.

6.7 NO LEGAL OBLIGATION TO PAY

Services that are paid for or furnished by the United States Government or one of its agencies, or by a state or one of its agencies or under any other laws (except as required under Medicaid provisions or Federal Law) are excluded. Services and supplies furnished under or as part of a study, grant, or research program are excluded, except for those Medically Necessary services incurred during a clinical trial as specified in Article 5.30. Services for which a Member has no financial liability or that would be provided at no charge in the absence of insurance are excluded.

6.8 THIRD PARTY LIABILITY

Services that are paid for or furnished for the treatment of Injuries, Illness, or other conditions, to the extent the Member recovers damages from a third party or insurance carrier are excluded.

6.9 CUSTODIAL CARE

Custodial Care, nursing home care, rest cures and domiciliary care, along with all related services. Care is considered custodial when it is primarily for meeting personal needs. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing,

shopping, eating and preparing meals, performing general household services, taking medicine, or furnishing other home services mainly to help people in meeting personal, family or domestic needs to include extraordinary personal needs created by the Illness of a Family Dependent. Custodial care is excluded regardless of the location or setting. All services provided to persons confined to long-term care facilities and boarding homes is excluded. Care for long-term patients who are ventilator dependent is also excluded.

6.10 BLOOD

Replacement of whole blood and blood products are excluded.

6.11 EXAMS

Physical examinations for employment, school, camp, sports, licensing, insurance, adoption or marriage, or other examinations ordered by a third party are excluded.

6.12 COSMETIC SERVICES AND SURGERY

Cosmetic services and surgery are excluded. Cosmetic surgery means surgery to change the texture or appearance of the skin; or the relative size or position of any part of the body; when such surgery is performed primarily for psychological purposes and is not needed to correct or substantially improve a bodily function. Removal of skin lesions is considered cosmetic unless lesions interfere with normal body functions or malignancy is suspected.

6.13 DENTAL AND ORAL SURGICAL SERVICES

Crowns, bridges, dentures, or other dental prosthetic devices, dental restorative care, periodontal care, treatment of impacted wisdom teeth (except as specified in Article 5.12.A), orthodontics, treatment for Temporomandibular Joint Dysfunction (TMJ), or orthognathic surgery, including Hospital and professional services and supplies associated with such care, are excluded. Preventive dental services are excluded unless provided in a Supplemental Benefit Explanation.

6.14 EXPERIMENTAL PROCEDURES OR TREATMENTS

Experimental and investigative procedures or treatments are excluded. Any treatment, procedure, facility, equipment, drug, device, or supply that We determine is not accepted as standard medical treatment for the condition being treated; or any item or technology requiring federal or other government agency approval which has not been granted at the time services are rendered are also excluded.

6.15 MATERNITY, FAMILY PLANNING, STERILIZATION, AND INFERTILITY

The following exclusions apply to family planning, elective sterilizations and infertility services:

- Any medical service(s), prescription drugs, medicine, supplies or procedures directly or indirectly related to the following are excluded: reversal of voluntarily induced sterilization, services related to sex transformation, and home delivery for childbirth.
- Any of these services when you or your spouse have had a voluntary sterilization procedure.
- Maternity services provided outside the Service Area within three (3) weeks of the estimated date of delivery are excluded unless prior authorization is given in writing by Us.

6.16 PROSTHETIC DEVICES, DISPOSABLE ITEMS, AND DURABLE MEDICAL EQUIPMENT

The following exclusions apply to prosthetic devices, disposable items and durable medical equipment:

- Over-the-counter devices and/or supplies (such as ACE wraps, elastic supports, finger splints and soft cervical collars) are excluded.

- Dental prosthesis, bionics, special shoes, sunglasses, corsets, clothing, disposable items, air mattresses, breast pumps, orthodontic braces, penile prostheses, orthotics, needles and syringes needed for non-diabetic reasons. Hearing aids and hearing related implants, including cochlear implants are excluded.
- Durable Medical Equipment that does not serve a medical purpose or cannot be used in a Member's home is excluded. Also, equipment that is generally not useful to a person without Illness, Injury or disease is excluded.
- Disposable items are excluded unless determined by Us to be medically necessary.
- Purchase or rental of supplies of common household use such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses, and water beds are also excluded.

6.17 PHARMACY SERVICES AND PRESCRIPTION DRUGS

Pharmacy services, prescription drugs or over-the-counter medications incidental to outpatient care and Urgent Care outside the Service Area are excluded, unless provided in a Supplemental Benefit Explanation or Rider issued by Us.

6.18 MENTAL HEALTH CARE SERVICES

Mental health care services (except for treatment of Serious Mental Illness & Substance-Related Disorders) are excluded unless provided in a Supplemental Benefit Explanation.

6.19 RADIAL KERATOTOMY AND EYE EXERCISES

Radial keratotomy, surgeries to correct myopia, and eye exercises are excluded.

6.20 THERAPY

Acupuncture; biofeedback; massage therapy; hypnotherapy; sleep therapy; weight reduction therapy; vocational therapy; marriage and sex counseling; behavior training; conduct disorders and related family counseling; and remedial education, including treatment of learning disabilities, congenital speech disabilities and attention deficit disorders or minimal brain dysfunction are excluded.

Therapy through behavior modification is excluded. Other therapy considered long-term (long-term therapy is more than sixty (60) days in duration from the onset of therapy) in the judgement of the Medical Director or Medical Director's Designee is excluded. Educational and other non-medical treatments for mental retardation are excluded.

6.21 COMPLICATIONS

Complications that occurred when a Member did not follow the course of treatment prescribed by a Participating Provider are excluded.

6.22 HOSPICE

The following hospice services are excluded:

- Health care, visits, medical equipment or supplies that are not included in the Participating Physician's recommended plan of treatment.
- Services in the Member's home outside the Service Area.
- Financial and legal counseling.
- Any service for which the hospice does not customarily charge the Member, or his or her family.
- Reimbursement for volunteer or spiritual counseling.

6.23 SURGICAL AND OTHER TREATMENT FOR OBESITY

Surgical procedures and associated care for the treatment of obesity, such as intestinal bypass surgery, stomach stapling, balloon dilation, wiring of the jaw, and procedures of similar nature, as well as the complications of such procedures, are excluded unless determined by Us to be the medically necessary course of treatment for co-morbid conditions. Surgery or hospitalization for weight reduction is excluded. Diet programs, including any tests, exams or services for diet programs, such as Optifast, Nutri-System and other similar diet programs are excluded.

6.24 ROUTINE FOOT CARE

Routine foot care is excluded, except for diabetic foot care. Routine foot care includes the removal or reduction of corns and calluses, clipping of the nails, treatment of flat feet, fallen arches, and chronic foot strain.

6.25 ILLEGALITY

We shall not be liable for any care of a condition to which a contributing cause was the commission of a felony or misdemeanor of which the Member is convicted or to which a contributing cause was the Member's engagement in an illegal activity or if the condition was intentionally self-inflicted. Services required due to accidents when the Member is convicted of driving while intoxicated or under the influence of drugs are excluded.

6.26 FOOD OR FOOD SUPPLEMENTS

Food or food supplements (for example protein) are excluded. Tube feeding is covered if it is the only source of nutrition. Nutritional counseling is excluded unless Medically Necessary and approved by Us.

6.27 GENETIC COUNSELING

Genetic counseling and genetic studies that are not needed for diagnosis or treatment of genetic abnormalities are excluded.

6.28 GROWTH HORMONE

Growth hormone for idiopathic short stature or that is not medically necessary, as determined by Us is excluded.

6.29 TRAVEL

Travel other than ground or air ambulance travel for Medical Emergencies is excluded, regardless of whether it is prescribed by a Physician or Provider.

6.30 IMMUNIZATIONS

Immunizations for travel or employment are excluded. Immunizations that are not considered routine childhood immunizations and/or immunizations that are not listed in the Wellness and Prevention Guidelines (Article 4) are excluded.

6.31 MILITARY SERVICE

Care for military service-connected conditions or disabilities to which the Member is legally entitled and for which facilities are available is excluded.

6.32 WAR OR ACT OF WAR

Services resulting from war or act of war are excluded.

6.33 APPOINTMENTS

Charges incurred by Members by not keeping or canceling Participating Physician and Participating Provider appointments are excluded.

6.34 HEARING AIDS

Hearing aids and cochlear implants are excluded.

6.35 RETROACTIVE REFERRALS

Retroactive referrals are excluded.

6.36 INJECTABLE MEDICATIONS

Injectable medications are excluded unless determined by Us to be medically necessary and administered in a doctor's office or at home by a home health care professional.

6.37 BREAST REDUCTION

Breast Reduction is excluded.

6.38 VARICOSE VEIN SURGERY

Varicose vein surgery is excluded.

6.39 BLEPHAROPLASTY (EYELID REPAIR)

Blepharoplasty (eyelid repair), is excluded.

ARTICLE 7 - COORDINATION OF BENEFITS, RIGHTS OF REIMBURSEMENT AND SUBROGATION

7.1 COORDINATION OF BENEFITS

Coordination of Benefits (COB) is a feature that prevents duplicate payment under this Health Plan and under (1) any group health insurance plan or arrangement, on an insured or uninsured basis; (2) group coverage through an HMO, service plan, group or individual practice or other pre-payment plan; (3) automobile or no-fault insurance; and (4) Medicare and other governmental benefits, except Medicaid and any other plan that is prohibited by law from coordinating benefits.

While eligible for coverage under this Health Plan, a Member may have coverage under Other Contracts for all or some of the same services. For example, a Member may be covered by an Employer's group insurance program and also by a Spouse's health benefit plan. Or, a Member may be covered by an Employer's group insurance program and also have coverage under a parent's health benefit plan.

If a Member files a claim under this Health Plan for a service that is also covered under Other Contracts, the payments will be coordinated. Coordinated means We will adjust Our benefit payment so the combined payments under this Health Plan and Other Contracts will be no more than 100% of the Allowable Expense.

An Allowable Expense is a usual, customary and reasonable item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Also, when benefits are reduced under a primary plan because a Member has not complied with the provisions of the primary plan, the amount of such reduction is not considered an Allowable Expense.

Once a Member has provided Us with the information about Other Contracts that cover him or her, We will handle this coordination. This will be done according to the order of benefit determination explained below. The plan that has the first obligation to pay or provide services is called the primary plan. Any other plan that covers a Member is called secondary.

COB affects benefits in the following manner when a Member is covered by more than one plan:

(1) If the total benefits of all contracts exceed the Covered Services a Member receives, the benefits We provide will be determined according to this provision.

(2) When We are primary, benefits will be paid without regard to any Other Contract.

(3) When We are secondary, benefits paid may be reduced and will not exceed the Allowable Expense remaining after payment by the Other Contract.

We will determine when We are primary or secondary according to the following order:

(1) The Other Contract with no COB provision is always primary.

(2) The contract covering the Member as an Employee or Subscriber is primary.

(3) When a Dependent Child or Disabled Dependent is covered by more than one contract of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary. If both parents have the same birthday, the contract that covered the parent longer will be primary and the contract which covered the other parent for a shorter period is secondary. If a Dependent is covered by two contracts of insurance and the Other Contract does not have this COB rule, the rule of the Other Contract will determine the primary and secondary contract. If the parents are separated or divorced, the following rules apply:

   (a) If the parent with custody has not remarried, his or her coverage is primary;

   (b) If the parent with custody has remarried, his or her coverage is primary, his or her Spouse's coverage is secondary and the coverage of the parent without custody is last;

(c) If a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent is primary from the date of decree;

(4) When a contract covers the Member as an Actively at Work Employee or a Family Dependent of such Employee and the Other Contract covers the Member as a laid-off or retired Employee or as a Family Dependent of such person, the contract that covers the Member as an Actively at Work Employee or Family Dependent of such Employee is primary.

(5) When the rules above do not apply, the contract that has covered the Member longer is primary.

If coverage under this Health Plan is primary, benefits will be paid as if a Member has no other coverage. However, if the coverage is secondary, Our payment will be 100% of the balance after the primary plan's payment or equal to the benefit that would have been provided if this Health Plan was primary, whichever is less.

When this Health plan is secondary, this plan will account for payments made by other plans. This plan will coordinate with other plans and will never pay more than what this plan would have paid if this plan were primary.

When this Health Plan is secondary, You are not required to follow this Health Plan's Authorization requirements. However, if the other plan has a managed care program, the other plan's managed care requirements must be followed to ensure maximum payment from both the primary and secondary (this Health Plan) programs.

Exceptions to the above are as follows:

(1) If You receive care for services not covered under the primary plan, but such services are covered under this Health Plan, then this Health Plan becomes primary for calculation of payment for these particular services. When this happens, applicable Authorization requirements of this Health Plan must be satisfied in order for benefits to be covered at the level described in this Health Plan.

(2) If a benefit maximum has been met (either a certain time period or dollar amount) for a particular service covered under the primary plan, and such service is also covered under this Health Plan, then this Health Plan becomes primary for the calculation of payment for this particular service, until such time as the benefit maximum renews (additional benefits become available) under the other plan.

If a Member is hospitalized upon becoming a Health Plan Member, any Other Contracts covering the Member at the commencement of the Hospital admission will be primary for that Hospital confinement only.

By accepting coverage under this Health Plan, a Member agrees to do two things to enable Us to coordinate benefits. First, when requested, a Member will supply Us with information about Other Contacts that cover the Member. Second, if We make a payment and later find that the other coverage should have been primary, the Member will return the excess amount to Us. By accepting coverage under this Health Plan, a Member has given Us the right to obtain information needed from others to coordinate benefits.

When submitting claims to Coventry for secondary processing, you must include a statement from the provider of service which indicates all necessary information to identify the patient, provider of service, date of service, type of service rendered, reason for service, amount billed and amount paid. You must also submit an explanation of benefit statement from the primary insurance carrier. If you are asking for a member reimbursement, you must also submit a receipt showing proof of payment. Submission of these claims must be done according to Article 12.2, Submission of Bills and Claims.

Full-time Working Spouse Coordination of Benefit Rules

Special Coordination of Benefit rules apply to spouses who work full-time and are eligible for medical coverage through their own employers.

If a spouse takes advantage of his/her own employer's medical coverage, that plan pays benefits first. This Health Plan will then pay additional covered expenses, if any, up to the maximum allowed under the Health Plan, not to exceed a limit of 100% in coverage from both plans combined.

If a spouse does not take advantage of his/her own employer's medical coverage, the State of Delaware will pay 20% of Covered Services provided by this Health Plan. This policy does not apply to:

- Spouses not working full-time;
- Spouses whose employer does not offer medical coverage;
- Spouses whose employer requires a contribution of more than 50% of the premium for the lowest benefit plan available (all flexible benefit dollars and/or credits available to the spouse are counted as contributions provided by the spouse's employer); or
- Eligible dependent children.

7.2 RIGHTS OF REIMBURSEMENT

This Article applies when a Member recovers damages, by settlement, verdict or otherwise, for an Injury, Illness, or other condition. If the Member has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, We will not cover either the reasonable value of the services to treat such an Injury or Illness or the treatment of such an Injury or Illness under this Health Plan.

However, if We pay or provide benefits under this Health Plan for such an Injury, Illness or other condition, the Member shall promptly reimburse Us, from the settlement, verdict or insurance proceeds received by the Member, for the reasonable value of the medical benefits paid for or provided by Us.

The Member hereby grants to Us a lien against the proceeds of any such settlement, verdict or other amounts received by the Member. The Member hereby assigns to Us any benefits that the Member may have under any automobile or other coverage to Us in order to enforce Our rights under this Health Plan. The Member shall sign and deliver, at Our request, any documents needed to protect such lien or to effect such assignment of benefits.

The Member shall cooperate with Us, including signing and delivering any documents that We reasonably request in order to protect Our rights of reimbursement, providing any relevant information, and taking such actions as We reasonably request in order to assist Us in making a full recovery of the reasonable value of the benefits provided under this Health Plan. The Member shall not prejudice Our right of reimbursement.

We shall be responsible only for those legal fees and expenses to which We agree in writing.

7.3 SUBROGATION

This Article applies when another party is, or may be considered, liable for a Member's Injury, Illness or other condition (including insurance carriers who are so liable) and We have provided benefits under this Health Plan.

To the extent of the reasonable value of the services provided, We are subrogated to all of the Member's rights against any party liable for the Member's Injury or Illness or any party (including any insurance carrier) or for the payment for the medical treatment of such Injury or occupational Illness. We may assert this right independently of the Member.

The Member is obligated to cooperate with Us in order to protect Our subrogation rights. Such cooperation shall include providing Us with any relevant information, signing and delivering such

documents as We reasonably request to secure Our subrogation claim, and obtaining Our consent before releasing any party from liability for payment of medical expenses.

If the Member enters into litigation or settlement negotiations regarding the obligations of other parties, the Member must not prejudice, in any way, Our rights under this Article. The costs of Our legal representation in matters related to subrogation shall be borne solely by Us. The costs of legal representation of the Member shall be borne solely by the Member.

ARTICLE 8 - ELIGIBILITY AND ENROLLMENT

8.1 WHEN COVERAGE BEGINS

If an Employee and his/her Dependents wish to enroll during the Open Enrollment Period, or when the Employee first becomes eligible, the Employee must request enrollment with their State of Delaware Agency Benefit Representative within 31 days of eligibility. Appropriate legal papers, if applicable, must be provided as well.

Coverage is effective on the date the change in eligibility status occurred. If an Employee or Dependent is not Enrolled within 31 days of becoming eligible, he/she cannot be added until the next Open Enrollment Period.

8.2 ENROLLMENT

If an Enrollee is actively at work and resides or works in the Service Area, he or she may enroll for coverage in accordance with the eligibility and enrollment criteria below.

Special Enrollment Rules apply if an Employee and/or Dependent who is eligible but not enrolled wishes to enroll. The rules apply if

(1) The Employee is covered under a group health plan (including COBRA continuation coverage) at the time coverage is initially offered.

(2) The Employee states in writing that the other coverage is the reason for declining enrollment.

(3) The other coverage that the Employee had is either:

(a) COBRA continuation coverage that is exhausted, or

(b) The coverage is other health plan coverage and is terminated due to loss of eligibility or termination of employer contributions to the coverage and not due to failure to pay or termination for cause.

(4) The Employee and/or Dependent becomes eligible due to marriage, birth, adoption, or placement for adoption.

A. Employees

An Employee is eligible to be covered under the State of Delaware's plan if:

(1) You are a regular officer or employee of the State of Delaware

(2) You are a regular officer or employee of a State of Delaware agency or school district

(3) You are a pensioner already receiving a State of Delaware pension

(4) You are a pensioner eligible to receive a State of Delaware pension

(5) You are a per diem and contractual employee of the Delaware General Assembly and have been continuously employed for 5 or more years

(6) You are a regularly scheduled full-time employee of any Delaware authority or commission participating in the State of Delaware's Group Health Insurance program

(7) You are a regularly scheduled full-time employee of the Delaware Stadium Corporation or the Delaware Riverfront Corporation

(8) You are a paid employee of any volunteer fire company participating in the State of Delaware's Group Health Insurance program

(9) You are a regularly scheduled full-time employee of any county, soil and water conservation district or municipality participating in the Group Health Insurance program

(10) You are receiving or eligible to receive retirement benefits in accordance with the Delaware County and Municipal Police/Firefighter Pension Plan with Chapter 88 of Title 11 or the county and municipal pension plan under Chapter 55A of Title 29

B. Spouse

An Employee's legal spouse is eligible to enroll for coverage under the State's plan (Delaware law does not recognize common law marriage). An ex-spouse may not be enrolled in the State's plan, even if a divorce decree requires that an Employee provide coverage for an ex-spouse.

NOTE: If you are married, You must complete a *State of Delaware Spousal Coordination of Benefit Form* at the time You request enrollment. Please refer to Article 7.1, "Full-time Working Spouse Coordination of Benefit Rules."

C. Dependent Child

A dependent child may be eligible to enroll for coverage if he or she is an unmarried child under age 21 (or age 24 for a Full-time Student) who is

- born to or legally adopted by an eligible Employee or his/her spouse, and dependent on the Employee, or Employee's spouse; or
- not born to or legally adopted, but resides with the Employee or spouse in a regular parent-child relationship and is dependent upon the Employee or the Employee's spouse for at least 50% of his/her support. A *Statement of Support* form must be completed by the Employee and provided to their State of Delaware Agency Benefit Representative. If the child's natural parent resides in the same household as the insured Employee or insured Employee's spouse, the child is not considered to be living in a parent-child relationship with the Employee or spouse and will not be eligible for coverage.

Coverage for an eligible dependent child ends the last day of the calendar year in which the eligible dependent turns age 21 unless a Full-time Student or Disabled Dependent.

(1) Newborn or Adopted Child

A newborn or adopted child is covered from the moment of birth or Date of Adoption for a period of 31 days. To continue coverage for a newborn or adopted child beyond the 31-day period, the Employee must request enrollment within this thirty-one (31) day period with their State of Delaware Agency Benefit Representative. If enrollment is not requested within 31 days of the child's birth or Date of Adoption, coverage for the newborn or adopted child will terminate at the end of the 31-day period. Employee should call the Health Plan as soon as possible to choose a Primary Care Physician.

(2) Full-time Student

A Full-time Student is covered if he/she is under 24 years of age and is enrolled in and attending full-time (12 credit hours per semester) a recognized course of study or training in a public or private secondary school, college, university, or licensed trade school. Full-Time Student status continues during regularly scheduled school vacation periods, absence from classes for up to four months due to physical or mental disability, or temporary residence outside the Service Area for the purpose of attending school. Full-Time Student status does not continue when the student is absent from classes for personal reasons. We reserve the right to request verification of Full-Time Student status.

Coverage for a Full-Time Student ends the last day of the month in which the Full-Time Student reaches age 24 or the last day of the month he or she graduates or leaves school, whichever comes first.

(3) Disabled Dependent Child

A Dependent Child may continue coverage under this Health Plan if he or she is incapable of self-sustaining employment and chiefly dependent on the Subscriber for support due to mental incapacitation or physical handicap prior to reaching age 21 (or 24 if a Full-time Student). We reserve the right to periodically request proof of disability.

ARTICLE 9 - CONTINUING COVERAGE

When a Member loses coverage under this Health Plan, he or she may have the option to continue his or her current group health care coverage or convert to individual health care coverage, as explained below.

9.1 CONTINUING GROUP COVERAGE UNDER FEDERAL LAW

Under Federal law, an Employer who has more than twenty (20) Employees is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA requires an Employer to offer the option to continue the group's current health care coverage to Members who have one of the following qualifying events:

(1) An Employee who is terminated for any reason other than gross misconduct; who is laid-off; or whose hours are reduced. Coverage may be continued for the Employee and his or her Family Dependents for up to 18 months.

(2) An Employee or his/her Family Dependents who are determined to have been disabled for Social Security purposes at the time of the termination, lay-off or reduction in hours may extend coverage for up to 29 months.

(3) A Family Dependent whose coverage ceases under the terms of this Health Plan, or because of divorce, legal separation, the Subscriber's death, or the Subscriber becoming eligible for Medicare. Coverage for Family Dependents may be continued for up to 36 months if there is a legal separation or the Subscriber has died.

(4) In cases of Chapter 11 bankruptcy, a retiree and a beneficiary whose coverage is substantially reduced within one year before or after the Employer filed for bankruptcy. Coverage for the surviving Family Dependents or a retiree who has died after the filing of the bankruptcy may continue for up to 36 months.

You need to notify the State within 30 days of a divorce, child losing dependent status or if Social Security determines You are no longer disabled.

The Member has 60 days from the date he or she receives notification from the State to elect COBRA coverage. The State requires the Member to pay the full cost of the COBRA coverage. Premium payments may not exceed 102% of the Premium payments being paid for similarly situated Employees (150% for months 19-29 for continuation of coverage due to disability).

Under Federal Law, COBRA coverage ends at the earliest of the following:

(1) When the Employer ceases to provide any group Health Plan for any Employee.

(2) When the Member fails to make the required Premium payment on a timely basis.

(3) When the Member becomes covered under another group Health Plan that does not include a pre-existing condition clause.

(4) When the Member becomes entitled to benefits under Medicare.

Once a Member is no longer eligible to receive COBRA coverage, the Member is eligible for individual conversion coverage as described below.

This explanation is merely a general summary of a Member's continuation of coverage rights under COBRA. The Employer is responsible for administering COBRA coverage. It is important to note that the Internal Revenue Service may change or amend COBRA from time-to-time. This is not a legal opinion.

You should contact CobraServ at 800-877-7994 if you have any questions.

9.2 INDIVIDUAL COVERAGE

When, and only when, a Member becomes ineligible for or has exhausted the group coverage provided above, the Member may convert to direct pay coverage. The Member must send to Us an application for direct pay coverage at least 31 days before the group coverage ends. The Member's application must include payment for 3 months coverage at the direct pay coverage Premium in effect at that time. Members will be billed quarterly after the initial payment. A Member may obtain an application and Premium amounts for direct pay coverage by writing to Us. Direct pay coverage is subject to periodic changes in benefits and Premium as determined by Us. Members will receive notice within 31 days of any changes in benefits or Premium. The Member will not be allowed to convert to direct pay coverage if any of the following occurs:

- Group coverage available under this Health Plan ended because of nonpayment of Premium, Copayments, Coinsurance, or bills for unauthorized or non-Covered Services;
- The Employer, Medicare or other group affiliation replaces the Health Plan with another means of group coverage;
- The Member moves out of the Service Area;
- Group coverage available under this Health Plan ended because of cause under Article 9.2; or
- The Administrative Services Agreement is terminated.

9.3 MEDICARE ELIGIBILITY

At age 65 You become eligible for Medicare. Medicare is provided by the Federal Government and is not part of the State's Health Plan. If You are an active Employee working at age 65, You have a choice of benefit plans:

- You can continue coverage in this plan until You retire and this plan will be primary.
- You can be covered by Medicare and Medicare will be primary. You will not have any other coverage through the State of Delaware.

About 3 months before You reach age 65, contact the State and the Social Security Administration. Follow the same guidelines when Your spouse reaches age 65.

If Your option is Medicare Supplemental Coverage with Coventry Health Care of Delaware, You must be enrolled in and keep both Parts A and B of Medicare to be covered.

ARTICLE 10 - COMPLAINTS AND APPEALS

A Member may occasionally encounter situations where the performance of the Health Plan does not meet expectations. When this occurs, the Member or Authorized Representative may call or write Us to file a complaint or an appeal. We will consider all the facts and handle all complaints and appeals promptly and fairly.

Please note: Benefits are paid only if the services provided are Medically Necessary and are Covered Services under this Agreement.

10.1 COMPLAINTS

Complaints may be expressed by telephone or in person and are handled by one of Our Customer Service Representatives. The Customer Service Representative may involve other staff members of the Health Plan or Providers of health care before making a determination. The objective is to review all the facts and to handle the Complaint as quickly and as courteously as possible.

The address and telephone numbers for complaints are:

Coventry Health Care of Delaware, Inc.
Customer Service Department
Pencader Corporate Center
211 Lake Drive
Newark, Delaware 19702-3320
(302) 283-6500 or (800) 833-7423

10.2 APPEALS

If the complaint relates to an Adverse Benefit Determination and the Member and/or the Authorized Representative are dissatisfied with resolution of the complaint or does not wish to first file a complaint, he or she may file an Appeal within 180 days of the Adverse Benefit Determination by writing or calling:

Coventry Health Care of Delaware, Inc.
Appeals Department
2751 Centerville Rd, Suite 400
Wilmington, Delaware 19808-1627
Phone: (302) 283-6500 or (800) 833-7423

We will review the Appeal to determine if it is an Administrative Appeal, Medical Necessity Appeal, or other Appeal involving medical judgment.

A. Administrative Appeals

An Administrative Appeal is an Appeal of an Adverse Benefit Determination that was not based, in whole or in part, on medical judgment.

The Member or Authorized Representative has 180 days after the date of the Adverse Benefit Determination in which to file an Appeal. The Member or Authorized Representative may request the Appeal either in writing or verbally to Customer Service, stating the reason for dissatisfaction. The Administrative Appeal Committee will review the Appeal.

(1) First Level Appeal

First Level Administrative Appeals are concluded as follows:

- Urgent Care/Expedited Administrative Appeals – Within thirty-six (36) hours after receipt of the Appeal. We will notify the Member and/or Authorized Representative verbally and will provide written notice within thirty-six (36) hours after receipt of the Appeal.

- Pre-service Administrative Appeals - within fifteen (15) days of the request for Appeal.
- Post-service Administrative Appeals - within thirty (30) days of the request for Appeal.

We will advise the Member or Authorized Representative of the determination in writing giving the reason for the decision.

If the Member or Authorized Representative is still dissatisfied with the decision, he or she may, within 31 days after notice of the 1st level Appeal decision, request a Second Level Appeal.

(2) Second Level Administrative Appeal

The Member or Authorized Representative may file a Second Level Administrative Appeal within 31 days if he or she is not satisfied with the First Level Appeal decision. The Second Level Appeal will be conducted by a panel selected by Us and consisting of at least one to three members of Health Plan or Coventry senior management who had no direct involvement with the case prior to this review.

Any supporting material may be submitted to Us for consideration by the Committee. At any time during the Appeal process, You have the right to receive, free of charge, reasonable access to and copies of documentation relevant to the Appeal.

Second Level Administrative Appeals are concluded as follows:

- Urgent Care/Expedited Administrative Appeals - within thirty-six (36) hours after receipt of the Appeal. Oral communication of the decision will be followed up with a written notice within thirty-six (36) hours after the request for Second Level Appeal.
- Pre-service Appeals - within fifteen (15) days of the request for a Second Level Appeal.
- Post-service Appeals - within thirty (30) days from date of the request for a Second Level Appeal.

We will write the Member and/or Authorized Representative advising of the decision.

B. Medical Necessity Appeals

A Medical Necessity Appeal is an appeal of an Adverse Benefit Determination by Us that a service is/was experimental, investigational, for cosmetic purposes, or not medically necessary.

The Member or Authorized Representative has 180 days after the date of the Adverse Benefit Determination in which to file an Appeal. The Member or Authorized Representative may request the Appeal either in writing or verbally to Customer Service, stating the reason for dissatisfaction. The Medical Necessity Appeal Committee will review the Appeal.

You may ask Us to appoint a staff member to assist with the Appeal at any time during the process.

(1) First Level Appeal

The Member or Authorized Representative may file a First Level Appeal by either using the special form that is available from Customer Service or by sending Us a letter describing the reason for the appeal. The First Level Appeal Committee will include a Medical Director and/or a physician designee who have no prior involvement in the case and who are not subordinates of the individual who rendered the Adverse Benefit Determination. If the Medical Director and/or physician designee are not in the same or similar specialty of the case under review, the Committee will also consult a health care professional who has training and experience in that field of medicine.

First Level Appeals are concluded as follows:

- Urgent Care/Expedited Appeals - within thirty-six (36) hours after receipt of the Appeal. We will notify the Member and/or Authorized Representative verbally and will provide written notice within thirty-six (36) hours after receipt of the Appeal.
- Pre-service Appeals - within 5 business days of receipt of the Appeal. If We provide notice verbally, then We will follow up with written notice within 5 days of the verbal notice.
- Post-service Appeals - within 30 calendar days from date of the request for a First Level Appeal.

We will advise the Member or Authorized Representative of the determination in writing giving the reason for the decision. Our notice will give the Member or Authorized Representative instructions on how to proceed to a Second Level Appeal. If the Member or Authorized Representative is still dissatisfied with the decision, he or she may, within 31 days, request a Second Level Appeal in accordance with the instructions provided in the notice. The address and telephone numbers for Medical Necessity Appeals are indicated above.

(2) Second Level Appeal

The Second Level Appeal will be conducted by a panel selected by Us consisting of a Coventry or Health Plan senior manager and at least 2 physicians and/or health care professionals, at least one of whom who has the appropriate training and experience in the same or similar field of medicine as the procedure/service being reviewed. None of the committee members will be someone who made the Adverse Benefit Determination or involved in the First Level Appeal, or who is a subordinate of someone who made the Adverse Benefit Determination or was involved in the First Level Appeal.

A hearing will be convened during a reasonable time period so that the Appeal can be concluded within the time periods specified below. The Member or Authorized Representative will be notified in advance of the place, date and time of the hearing and of the right to receive, free of charge, reasonable access to and copies of documentation relevant to the Appeal. The Member or Authorized Representative may attend the Second Level Appeal, or if he or she cannot attend the hearing, the Member or Authorized Representative may communicate with the panel by conference call or other technology. We will hold the Second Level Appeal hearing during regular business hours at a location reasonably accessible to the Member or Authorized Representative. Any supporting material may be submitted before and at the hearing. The Member may also be represented by a person of his or her choice. During the hearing, the Member or Authorized Representative may ask questions of any panel members.

Second Level Appeals are concluded as follows:

- Urgent Care/Expedited Appeals - within thirty-six (36) hours after receipt of the Second Level Appeal. Oral communication of the decision will be followed up with a written notice within thirty-six (36) hours of receipt of the Second Level Appeal.
- Pre-service Appeals - within 15 calendar days from the date of receipt of the Second Level Appeal.
- Post-service Appeals - within 30 calendar days from date of the receipt of the Second Level Appeal.

We will write the Member and/or Authorized Representative advising of the decision. If the decision does not overturn the Adverse Benefit Determination and the First Level Appeal determination, the written notice will include instructions on how to proceed to a voluntary Third Level Appeal to be conducted by an external review organization.

(3) Voluntary Third Level Appeal

- The Member or Authorized Representative may file a Third Level Appeal within 60 days if he or she is not satisfied with the Second Level Appeal decision. The case will be assigned to an Independent Utilization Review Organization (IURO). We will advise the Member or Authorized Representative of the determination in writing giving the reason for the decision.

C. All Other Appeals Involving Medical Judgment

You may file an Appeal in response to an Adverse Benefit Determination that was not based on a Medical Necessity denial (as described above), but still was based on medical judgment in whole, or in part ("Medical Appeals").

The Member or Authorized Representative has 180 days after the date of the Adverse Benefit Determination in which to file an Appeal. The Member or Authorized Representative may request the Appeal either in writing or verbally to Customer Service, stating the reason for dissatisfaction. The Medical Appeal Committee will review the Appeal.

(1) First Level Appeal

The Member or Authorized Representative may file a First Level Appeal by sending Us a letter describing the reason for the Appeal. The First Level Appeal Committee will include one to three members of Our senior management who have no prior involvement in the case and who are not subordinates of the individual who rendered the Adverse Benefit Determination. The Committee will consult with a health care professional who has training and experience in the field of medicine related to the service/procedure being reviewed.

First Level Appeals are concluded as follows:

- Urgent Care/Expedited Appeals - within thirty-six (36) hours after receipt of the Appeal. We will notify the Member and/or Authorized Representative verbally and will provide written notice within thirty-six (36) hours after receipt of the Appeal.
- Pre-service Appeals - within fifteen (15) calendar days from date of the request for a First Level Appeal.
- Post-service Appeals - within thirty (30) calendar days from date of the request for a First Level Appeal.

We will advise the Member or Authorized Representative of the determination in writing giving the reason for the decision. Our notice will give the Member or Authorized Representative instructions on how to proceed to a Second Level Appeal. If the Member or Authorized Representative is still dissatisfied with the decision, he or she may, within 31 days after notice of the 1st level Appeal decision, request a Second Level Appeal in accordance with the instructions provided in the notice. The address and telephone numbers for Medical Appeals are indicated above.

(2) Second Level Appeal

The Second Level Appeal will be conducted by a panel selected by Us consisting of one to three members of Health Plan or Coventry senior management, none of whom will be someone who made the Adverse Benefit Determination or were involved in the First Level Appeal, or who are a subordinate of someone who made the Adverse Benefit Determination or was involved in the First Level Appeal. The Appeal Committee will consult with a health care professional who has the appropriate training and experience in the field of medicine for the service/procedure being reviewed.

A hearing will be convened during a reasonable time period so that the Appeal can be concluded within the time periods specified below. The Member or Authorized Representative will be notified in advance of the place, date and time of the hearing and of the right to receive, free of charge, reasonable access to and copies of

documentation relevant to the Appeal. The Member or Authorized Representative may attend the Second Level Appeal, or if he or she cannot attend the hearing, the Member or Authorized Representative may communicate with the panel by conference call or other technology. We will hold the Second Level Appeal hearing during regular business hours at a location reasonably accessible to the Member or Authorized Representative. Any supporting material may be submitted before and at the hearing. The Member may also be represented by a person of his or her choice. During the hearing, the Member or Authorized Representative may ask questions of any panel members.

Second Level Appeals are concluded as follows:

- Urgent Care/Expedited Appeals - within thirty-six (36) hours after receipt of the Second Level Appeal. Oral communication of the decision will be followed up with a written notice within thirty-six (36) hours of receipt of the Second Level Appeal.
- Pre-service Appeals - within 15 calendar days from the date of receipt of the Second Level Appeal.
- Post-service Appeals - within 30 calendar days from date of the receipt of the Second Level Appeal.

We will write the Member and/or Authorized Representative advising of the decision.

ARTICLE 11 - TERMINATION

11.1 VOLUNTARY TERMINATION

A. The Subscriber shall have the right to terminate this Health Plan by written notice to Us or his/her Employer. Such termination shall be effective on the last day of the month in which such notice is received by Us.

B. The Employer shall have the right to terminate this Health Plan as specified in the Administrative Services Agreement.

C. We shall have the right to terminate this Health Plan as specified in the Administrative Services Agreement.

11.2 TERMINATION OF A MEMBER FOR CAUSE

A. Failure to Make Payments.

The Member is expected to pay all Copayments, Coinsurance, Premium contributions and bills for unauthorized or non-Covered Services. In the event that the Member fails to make these payments, coverage may terminate.

B. Misuse of Membership Card.

If a Member permits the use of his/her or any other Member's Health Plan identification card by any other person, uses another person's card, or defaces the card in order to obtain services or a higher level of benefits, the identification card may be retained by Us and coverage of the Member may be terminated with thirty-one (31) days written notice. The Subscriber shall be liable to Us for all costs incurred as a result of the misuse of the identification card, except when the Member unwillingly permits another person to use his/her identification card (i.e. lost or stolen identification card).

C. Failure to Cooperate in the Coordination of Benefits.

If a Member fails to cooperate in the administration of the COB provisions set forth in this Health Plan, coverage will terminate after thirty-one (31) days written notice.

D. Lack of Satisfactory Physician/Patient Relationship.

If, after reasonable efforts, Participating Physicians are unable to establish or maintain a satisfactory Physician/patient relationship with a Member (i.e., Member exhibits abusive or disruptive behavior in a Physician's office, repeatedly refuses to accept procedures or treatment recommended by a Participating Physician, and/or attempts to secure services in a manner that impairs the ability of the Primary Care Physician to coordinate the Member's care), coverage will terminate after thirty-one (31) days written notice.

E. Loss of Eligibility.

Subject to the continuation and conversion privileges of this Health Plan, the coverage of any Member who ceases to be eligible shall terminate on the last day of the calendar month in which eligibility ceased, except in the case of divorce. In the case of divorce, coverage shall terminate on the actual date of the legal divorce.

F. Termination of Administrative Services Agreement.

Coverage will terminate, in accordance with the provisions of the Administrative Services Agreement, if the Administrative Services Agreement is terminated for failure to meet minimum enrollment requirements, because We amend the Contract and the Employer does not accept the amendment or for any other reason specified in the Administrative Services Agreement.

11.3 EXTENSION OF BENEFITS

If a Member is in the Hospital the date the Administrative Services Agreement terminates, inpatient Hospital coverage under the Health Plan will continue until the earlier of 10 days after the plan ends or upon discharge or transfer from the Hospital to which the Member is confined. All other benefits cease on the date you become ineligible for coverage.

11.4 NOTIFICATIONS

All notifications of termination shall be in writing and shall state the reasons for such action.

ARTICLE 12 - GENERAL CONDITIONS

12.1 MISREPRESENTATION OF FACTS

This Health Plan will automatically be voided retroactive to the date of enrollment if: (1) The Subscriber has provided false information on his/her Group Enrollment Form for membership; or (2) The Subscriber otherwise misrepresents a material fact. In either case, if that information is material to Our acceptance of the Subscriber's membership, this Health Plan will retroactively be voided.

12.2 SUBMISSION OF BILLS AND CLAIMS

You do not have to submit a claim when you go to a Participating Provider. However, there may be an occasion when You need to submit a claim, such as emergency care services received out-of-network. Written proof of loss (itemized statements of medical Services provided) must be sent to Us within ninety (90) days after the date of loss (the date of such Services). Failure to furnish such statements within the ninety (90) days shall not invalidate or reduce any claim if it was not reasonably possible to provide the statements within ninety (90) days. Except in the absence of legal capacity, bills will not be accepted later than one (1) year from the time proof is otherwise required.

When you use a Non-Participating Provider for emergency care services out of the area and submit a claim to Us, it is Your responsibility to apply any payments we make to You for Covered Services to the Non-Participating Provider’s claim.

12.3 EVENTS BEYOND CONTROL

To the extent that a natural disaster, riot, civil insurrection, epidemic or any other emergency or similar event not within Our control results in Our being unavailable to provide or arrange for the care and services that We have agreed to provide in this Health Plan, We are required only to make a good-faith effort to provide or arrange for such care and services, taking into account the impact of the event.

In such event, We will be liable for reimbursement of the expenses the Member necessarily incurs in procuring such care and services as Our Physician agrees were Medically Necessary and covered under this Health Plan, to the extent prescribed by Applicable State law.

For purposes of this section, an event is not within Our control if We cannot exercise influence or dominion over its occurrence.

12.4 RELATIONSHIP OF PARTIES

The relationship between Us, Participating Providers, and the Employer is a contractual relationship between independent contractors. The relationship between a Participating Provider and any Member is that of Provider and patient. Participating Providers have and are subjected to the same duties, liabilities and responsibilities toward Members that generally exist between any patient and health care Provider. The relationship between Us, the Employer and Members is one that is based on the receipt of Premium payments. Once the Premium payments are received, We arrange for provisions of Covered Services to Members. In doing so, We enter into Health Plans with Providers of health care to enable Us to fulfill Our obligations under this Health Plan.

12.5 ACCESS TO RECORDS AND CONFIDENTIALITY

As part of this Health Plan, the Member authorizes Us to have access to any health records and medical information held by any health care Provider who delivers health services to the Member under this Health Plan. The Member also authorizes Us, or its representatives to use his/her general medical record, when necessary, for: claims processing, including claims We make on the Member's behalf for reimbursement; quality assessment; underwriting (for the purpose of

reinstatement or adding a Family Dependent); and evaluation of potential or actual claims against Us.

12.6 PROCEDURE TO REQUEST CERTIFICATE OF CREDITABLE COVERAGE

A federal law called HIPAA requires that the State of Delaware Group Health Plan (the "Plan") provide a Certificate of Creditable Coverage (a "Certificate") to each individual who requests one so long as it is requested while the individual is covered under the Plan or within 24 months after the individual's coverage under the Plan ends. A Certificate will also be automatically issued upon the termination of any individuals covered under the Plan, whether or not a request is made. The request can also be made by someone else on behalf of an individual. For example, an individual who previously was covered under this Plan may authorize a new health plan in which the individual enrolls to request a Certificate from this Plan. An individual is entitled to receive a Certificate upon request even if the Plan has previously issued a Certificate to that individual.

Requests for Certificates should be directed to your organization's Human Resources Office.

All requests must include:

- The name of the individual for whom the Certificate is requested;
- Where a certificate is requested for a dependent individual, the name of the participant who is enrolled in the Plan; and
- A telephone number to reach the individual for whom the Certificate is requested or the participant who enrolled the individual, in the event of any difficulties or questions.
- The name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- The address to which the Certificate should be mailed; and
- The requester's signature.

After receiving a request that meets these requirements, your organization's Human Resources Office will send a request to the State of Delaware COBRA/HIPAA Administrator to provide the Certificate as soon as administratively feasible.

12.7 CONFLICTS WITH EXISTING LAWS

In the event any term or condition of this Health Plan is found to be in irreconcilable conflict with Applicable State or Federal law, that law shall pre-empt only that provision of this Health Plan that is in conflict.

12.8 AMENDMENTS TO THIS HEALTH PLAN

Amendments that We make part of this Health Plan, or send to the Member at a later time, are incorporated and are fully a part of this Health Plan.

ARTICLE 13 - DEFINITIONS

Actively at Work: An Employee who is regularly scheduled to work those hours per week and months per year as defined in the Administrative Services Agreement, thereby making that Employee eligible for Covered Services under the terms of this Health Plan. An Employee is considered Actively at Work on the following days:

- a full normal work day of his or her regular duties;
- a weekend, except for one or both of these days if they are scheduled days of work;
- holidays, unless such holiday is a scheduled work day;
- paid vacations;
- any regularly scheduled non-working day;
- any non-scheduled non-working day;
- excused leave of absence, except medical leave; and
- emergency leave of absence, except emergency medical leave.

Administrative Services Agreement: A contract, signed by the Health Plan and the Employer and filed with the Employer, that sets out additional terms of coverage for Subscribers and their Family Dependent who receive Health Plan coverage through their Employer.

Allowable Expense: A usual, customary and reasonable item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Dental care, vision care, prescription drug and hearing aid programs are not an Allowable Expense. Also, when benefits are reduced under a primary plan because a Member has not complied with the provisions of that plan, the amount of such reduction is not considered an Allowable Expense.

Applicable State: The State(s) in which the Health Plan is duly licensed. In the case of multiple states, the state where the Health Plan executed the Administrative Services Agreement will apply unless state residency laws are required.

Authorization: An approval of a benefit by Us in advance of Member receiving certain services. We use a series of reviews to make sure the use of health care services is appropriate for the Member's condition. Participating Providers are responsible for obtaining Authorization from Us before a Member receives the service. A list of services requiring Authorization is in Article 2.4.A.

Authorized Representative: An individual authorized by the Member or state law to act on the Member's behalf to submit appeals and file claims. A Provider may act on behalf of a Member with the Member's express consent, or without the Member's express consent in an emergency situation.

Case Management: A systematic process performed by the Health Plan to:

- identify high cost cases;
- assess potential opportunities to coordinate care;
- develop treatment plans that improve quality and control costs; and
- manage total health care to ensure optimum outcome.

Coinsurance: The Member's responsibility to pay a share of the amount approved for payment by the Health Plan based on charges submitted by the Participating Physician and Participating Provider, as specified in the Schedule of Benefits.

Copayment: The Member's responsibility to pay a dollar amount per service, as specified in the Schedule of Benefits.

Coventry Health Care of Delaware, Inc.: A licensed health maintenance organization in the States of Delaware and Maryland.

Covered Services: Except as expressly limited or excluded by this Health Plan, those Medically Necessary services as indicated in Article 3 of this Health Plan, the Schedule of Benefits and the applicable Supplemental Benefit Explanations or Riders.

Customer Service Department: The department of the Health Plan that provides information, resolves complaints and maintains effective communication with Members.

Date of Adoption: The earlier of:

- a judicial decree of adoption; or
- the assumption of custody, pending adoption, of a child by a prospective adoptive parent.

Dependent Child(ren): An unmarried person who has not yet reached the Limiting age (except in the case of Disabled Dependents), including:

- a natural child;
- a stepchild;
- an adopted child or child in the process of being adopted, from the Date of Adoption; or
- a child for whom the Subscriber has the legal obligation to provide coverage pursuant to a qualified medical child support court order.

A Dependent Child may not be denied coverage on the grounds that the Dependent Child:

- was born out of wedlock;
- is not claimed as a dependent on the Member's federal income tax return; or
- does not reside with the Member or in the Health Plan's Service Area.

Detoxification: Treatment by medication, diet, rest, fluids, and nursing care to restore physiological functioning after the overuse of alcohol, barbiturates, other addictive drugs, or the overdosage of therapeutic agents that are not pharmacologic agents of abuse.

Disabled Dependent(s): An unmarried Dependent Child who at the time of reaching the Limiting Age, is incapable of self support because of mental retardation or physical handicap that commenced prior to the Dependent Child's attaining the Limiting Age.

Durable Medical Equipment Reference List: A list by category or item of covered equipment which is designed for repeated use, serves primarily a medical purpose, and is appropriate for use in a Member's home.

Effective Date: The date, as specified in the Administrative Services Agreement, that coverage begins for services under the terms of this Health Plan for those Subscribers and their Family Dependents who enrolled for Health Plan coverage during the Open Enrollment Period and are accepted by the Health Plan for coverage.

Employee: One who works for an Employer and receives wages or a salary.

Employer: A company with whom the Health Plan has a signed Administrative Services Agreement to provide Subscribers and their Family Dependents the benefits and services under the terms of this Health Plan.

Family Dependents: Family Dependents under family coverage are limited to the Subscriber's Spouse, Dependent Child, and Disabled Dependent.

Full-Time Student: A Full-Time Student is a Dependent Child:

- under twenty-four (24) years of age; and
- enrolled in and attending full-time (twelve (12) credit hours per semester) a recognized course of study or training in a public or private secondary school, college, university, or licensed trade school, and provides a Registrar's letter of student status confirmation as evidence thereof, upon the Health Plan's request.

Full-Time Student status continues during:

- regularly scheduled school vacation periods;
- absence from classes, in which enrolled, for up to four months due to physical or mental disability (Note: this does not include absence from classes for personal reasons); or
- temporary residence outside the Service Area attend school.

Coverage for a Full-Time Student ends the last day of the month of the Full-Time Student's twenty-fourth (24th) birthday, or the last day of the month he or she graduates or leaves school for personal reasons.

Group Enrollment Form: A Coventry enrollment form or a PHRST electronic enrollment form.

Health Plan: Coventry Health Care of Delaware, Inc.

Hospital: An institution that maintains affiliation or contractual agreement with the Health Plan for Hospital services or that is otherwise specified by the Health Plan and that is either:

- An institution that is primarily engaged in providing, on an inpatient basis, medical care and treatment for sick and injured persons through medical, diagnostic and major surgical facilities, under the supervision of a staff of Physicians, and with (24) twenty-four-hour-a-day service; or
- An institution not meeting all the requirements specified above, but that is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or Title XVIII of the Social Security Act of 1965 as amended. In no event shall the term "Hospital" include a convalescent nursing home or any institution, or part thereof, that is used as a convalescent facility, rest facility or nursing facility for the aged.

Illness: A sickness or disease including all related conditions and recurrences. Illness also includes pregnancy and all related conditions, and chemical detoxification.

Injury: An accident to the body requiring medical or surgical treatment.

Limiting Age: The last day of the calendar year in which an eligible dependent turns age 21 or the last day of the month in which a full time student turns age 24, graduates or leaves school, whichever comes first.

Medical Director: The Physician so specified by the Health Plan as the Medical Director.

Medical Director's Designee: Health Plan staff that is authorized to act on behalf of the Medical Director. The Medical Director's Designee acts under the general guidance of and in consultation with the Medical Director.

Medical Emergency: the sudden and acute onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Medically Necessary: Any service or supply for the prevention, diagnosis or treatment which is:

- consistent with Illness, Injury or condition of the Member;
- according to the approved and generally accepted medical or surgical practice prevailing in the geographical locality where, and at the time when, the service or supply is ordered. Determination of "generally accepted practice" is the discretion of the Medical Director or designee. Upon disagreement between a Member and a Participating Physician as to the Medical Necessity of a particular service, the Medical Director or designee shall make the final determination of Medical Necessity.

Medicaid: Title XIX of the Social Security Act and all amendments thereto.

Medicare: Title XVIII of the Social Security Act and all amendments thereto.

Member: Any Subscriber or Family Dependent duly enrolled in the Health Plan.

Notice of Benefit Determination: A notice of approval, denial, reduction or termination of benefits, or the failure to provide or pay for benefits.

Open Enrollment Period: A time period established by an Employer when eligible Employees are offered the option to choose, change or reallocate benefits.

Other Contract: Any arrangement providing health care benefits or services. This includes:

- group, blanket, or franchise insurance coverage;
- group or individual practice or other prepayment coverage;
- labor management trusteed plans;
- union welfare plans;
- Employer organization plans, or Employee benefit organization plans; or
- any tax supported or governmental program, including Workers' Compensation.

Participating Physician: Any doctor of medicine or osteopathy who is licensed to practice medicine and has a contractual arrangement with the Health Plan for the provision of Covered Services to the Health Plan's Members.

Participating Provider: Any Hospital, Skilled Nursing Facility, individual, organization, or agency:

- licensed to provide professional services within the scope of that license or certification; and
- has a contractual arrangement with the Health Plan for the provision of Covered Services to the Health Plan's Members.

Physician: Any doctor of medicine or osteopathy who is licensed to practice medicine.

Post-service Claim: A claim for medical care that the Member has already received or any claim that is not a Pre-service Claim.

Premium(s): The amount of payment for a contract with Coventry Health Care of Delaware, Inc. for health maintenance organization Covered Services, made by Members or through the Subscriber's Employer to the Health Plan, before a Member seeks such Covered Services.

Pre-service Claim: A request for a benefit for which authorization is required in advance of the Member obtaining medical care for a service that has not already been provided.

Primary Care Physician: Any duly licensed doctor of medicine or osteopathy in the practice of medicine in the Applicable State, and:

- associated with or engaged by the Health Plan, in the specific medical fields of Internal Medicine, Family Practice, or Pediatrics; or
- who is specified as a Primary Care Physician by the Health Plan for the purpose of this Health Plan.

Provider: Any Hospital, Skilled Nursing Facility, individual, organization or agency licensed to provide professional services within the scope of that license or certification.

Rehabilitation: Methods and techniques (sometimes termed tertiary prevention) used to achieve optimum patient functioning and adjustment, and to prevent relapses or recurrences of illness.

Referral: A Primary Care Physician's assignment of a Member to a specialist without the need for the Health Plan's authorization. Referrals do not need written notice to or permission from Us in order for the Member to receive specialist care.

Service Area: The geographical area serviced by the Health Plan and approved by the appropriate regulatory agency.

Special Enrollment Periods: Refers to an individual's ability to enroll in a health plan within a certain time period after the plan's regular enrollment period.

Spouse: A Subscriber's legal Spouse.

Subscriber: An Employee who is Actively At Work and:

- works or resides in the Service Area;
- signs the Group Enrollment Form;

- meets all applicable eligibility requirements in this Health Plan;
- is duly enrolled on the Effective Date; and
- for whom Premium has been accepted by the Health Plan.

Substance-Related Disorder(s): Habituation to, abuse of, and/or addiction to a chemical substance. Largely because of psychological craving, a substance-dependent person's life revolves around the need for the specific effect of a chemical substance or mood or state of consciousness. The term includes not only the addiction (physical dependence), but also substance abuse (pathological craving). Some examples of substances are alcohol, opiates, synthetic analgesics with morphine-like effects, barbiturates, other hypnotics, sedatives, some antianxiety agents, cocaine, phychostimulants, marijuana, and psychotomimetric drugs.

Supplemental Benefit Explanation: A description of coverage for services and benefits offered in addition to the coverage set forth in the Summary Plan Description.

Urgent Care: An unexpected Illness or Injury that is not life-threatening, but requires prompt medical attention. See the section on "Urgent Care" under the Article "Covered Services" for more details.

Urgent Care Center: A facility licensed to provide medical services for unexpected Illnesses or Injuries that require prompt medical attention but are not life or limb threatening. Urgent Care Centers usually do not provide the high tech care which is available at a Hospital emergency room for life or limb threatening situations.

Urgent Care Claim: A claim for medical care or treatment for which

- the application of the time periods for making non-urgent care determinations
  - could seriously jeopardize the life or health of the Member, or the Member's ability to regain maximum function; or
  - in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or
- We determine that a prudent lay person who possesses an average knowledge of health and medicine would judge to be an emergency; or
- that a physician with knowledge of the Member's medical condition determines is a claim involving a Medical Emergency.

An "Urgent Care Claim" may be a claim for a Medical Emergency.

We, Us or Our: Coventry Health Care of Delaware, Inc.

You or Your(s): The Member.